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ABSTRACT

This book describes a comprehensive assessment model called TREAT, an individually focused approach that draws information and interpretation from every available resource. Each chapter contains at least one case study to help counselors learn to apply the ideas in this book to real school situations. It discusses meeting federal regulations and guidelines regarding students with disabilities; assessing students for special education services eligibility; identifying and carrying out counseling goals for students with disabilities; working effectively with students' families; and making a real difference in the lives of students. This book is designed for school counselors who want to better understand and carry out their responsibilities to every student and for school leaders who want all students to get the counseling help that fits their needs. Includes Resource A, "Understanding and Coping with Learning Disabilities: A Support Group for Middle Schoolers with Specific Learning Disabilities," which describes techniques for conducting group sessions for male fifth and sixth graders with learning disabilities. Resource B, "Organization," provides contact information, a list of references, and a list of suggested readings. (Contains 18 additional references.) (Author/MKA)

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Julie P. Baumberger • Ruth E. Harper

Assisting Students With Disabilities

What School Counselors Can and Must Do

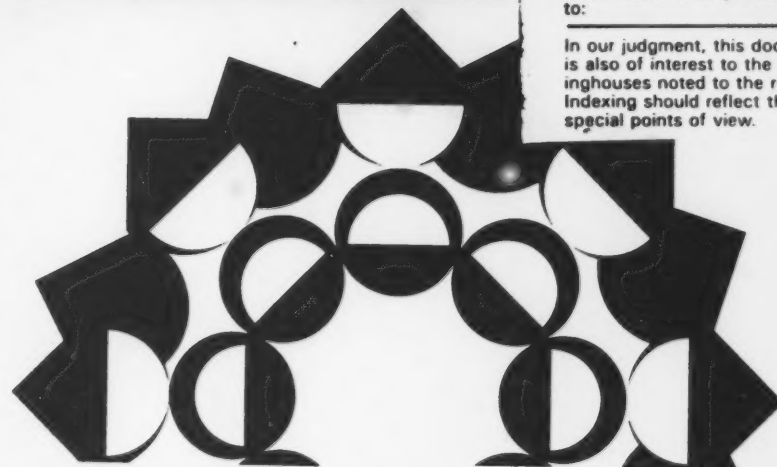
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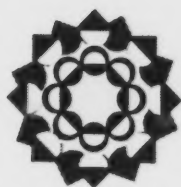
Practical Skills for Counselors

Jeffrey A. Kottler, Series Editor

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Assisting Students With Disabilities



Practical Skills for Counselors

Jeffrey A. Kottler, Series Editor

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Assisting Students With Disabilities: What School Counselors Can and Must Do

Julie P. Baumberger, Ruth E. Harper

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Assisting Students With Disabilities

What School Counselors Can and Must Do



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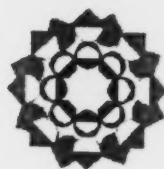
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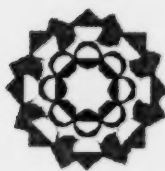


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Preface



This book is designed for practicing school counselors who want to function effectively and efficiently with all their students, atypical learners included. It provides counselors with clear directions for understanding their roles and responsibilities with children who have disabilities, as well as tools that will bring success in this work. A specific treatment approach is described, and case studies illustrate possible uses of this model. Examples of both goals and objectives—well and poorly written—are given, with special attention to writing and carrying out counseling-related activities for students with various disabling conditions. Information about working effectively with parents and siblings of children with disabilities is also included.

We wrote this book because we care about children who are sometimes left out. Students with disabilities are often, at best, given negative attention at school. At worst, they are ignored. In many school circumstances, it is as if they are invisible. There are few advocates for these children and youth. You seldom hear, "Let's start a group for students with learning disabilities." Rarely does one say, "Let's see how many students with disabilities we can get involved in at least one school activity this year!"

Kids at school need a sense of belonging and success. Students with disabilities do not get to experience either one very often. If only a small effort is made, it can make a real difference in the quality of their lives.

We see a clear need for school counselors to have a user-friendly reference at hand when they feel overwhelmed by the demands made upon them daily, especially with regard to their work with students in special education. Most counselor preparation programs simply cannot include more than a quick overview of the laws and a basic unit on goals and objectives. This book seeks to fill that gap, give more background on the mandates, and provide many more practical resources for counselors. It also emphasizes the unique perspective and strengths that school counselors can bring to the multidisciplinary teams that try to meet the needs of students with disabilities.

Overview of Contents

This book gives school counselors the tools they need to provide effective support and intervention for students with disabilities. Current federal regulations and guidelines are defined in clear terms, and many examples of how these laws can be creatively and competently met are provided.

Because school counselors are recognized as the behavioral and developmental experts in the school setting, they have a unique role in addressing the affective needs of students with disabilities. Counselors also know about working with families and can be especially valuable in mediating complex interactions between school personnel and parents. Counselors serve as consultants and advocates for staff and family members involved in special education meetings and relationships. Their role as participants in multidisciplinary teams is covered in Chapter 1.

Assessment techniques are covered in Chapter 2. Many commonly used tests and more informal assessments are described, and a case study shows how this information helps with determining eligibility for special education services.

A comprehensive model called "TREAT" is described in Chapter 3. TREAT stands for theoretical orientation, relationships, environment, adjunct services, and treatable goals and objectives that are helpful in designing effective strategies for students with disabilities. The model represents an individually focused approach that draws information and interpretation from all stakeholders (students, parents, teachers, counselors, and others). A worksheet for using the TREAT model is included.

Identifying and carrying out counseling goals for students with disabilities is the topic of Chapter 4. Examples of strong, measurable goals and objectives are provided. Clear rationale defines why writing goals in this manner is important. An effective method to evaluate this work is included.

Working with families is covered in Chapter 5. This chapter encourages counselors to adopt a systems perspective—at least to some extent—when working with students. Examples of how to establish trust with parents as well as how to look out for the needs of the siblings of children who are disabled are included.

Chapter 6 challenges and encourages school counselors to be assertive, professional, and positive about defining their roles when meeting the needs of children with disabilities. Counselors can and do make a difference in the lives of the children they serve, but they are sometimes expected to do too much or to assume inappropriate roles. Reading this book and identifying other learning goals for professional development will help counselors come to the growing challenges in their schools with a renewed sense of competence and confidence. In this way, school counselors can continue to demonstrate the value of their leadership and contributions to their schools, families, and society at large.

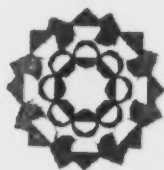
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Finally, we want to acknowledge the work of Jeffrey A. Kottler, series editor, for providing a model of how this kind of writing is done, as well as for believing that a book of this nature is needed by counselors.

About the Authors

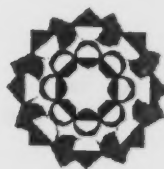


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Joining the Team



It is the end of another busy school day. As you walk to the main office, you mentally check off your accomplishments for the day. You have met with teachers, conducted classroom guidance, and led small groups on changing family systems. You worked on a curriculum for conflict resolution in the classroom and made a couple of telephone contacts with parents. It has turned out to be a productive day with few interruptions. A sense of satisfaction settles over you. You enter the main office to pick up your messages and a final cup of coffee before heading home. That is when you see it: the piece of paper that has the power to remove any sense of confidence and satisfaction you ever had with regard to your work. It is the dreaded "invitation" to an Individualized Education Program (IEP) meeting. All of your positive thoughts and energies about the day evaporate.

Although this is your third year as a school counselor in this particular school district, each time you are "invited" to an IEP

meeting your anxiety level increases. It is not that you do not want to be a team player, or that you do not care about students with disabilities. It is the awareness that you do not have the time or resources to provide the kind of results that are expected of you.

The request is usually the same. The student reportedly has low self-esteem, seems uninterested in school, will not finish his or her work and has authority figure problems. You are expected to "fix" one or all of these problems while the resource room and classroom teachers work on the academic goals and objectives. Tomorrow, during the meeting, the team will discuss the student's strengths and weaknesses and identify areas that need to be addressed. The portion of the IEP you are responsible for will read something like this: increase self-esteem and respect toward teachers and peers. The case manager may ask you, "Would you like to see the student once or twice a week?" and "How would you like me to word the objectives?" You'll look at him or her blankly, thinking, "I cannot see this kid once a week for an entire year—and what's the difference between a goal and an objective?"

You cannot remember ever learning how to write goals and objectives. As far as you can recall, it was not even mentioned in your counselor preparation classes. You vaguely remember a lecture on working with the needs of students with disabilities, but you are quite certain that no one ever taught you how to identify socioemotional or behavioral objectives for students with special needs or to write them out in measurable and defensible terms.

If this sounds all too familiar, you can either continue to approach IEP meetings with feelings of trepidation and inadequacy or take a proactive stance and meet these responsibilities with enthusiasm, hope, and a sense of competence. This book is a first step toward working collaboratively and effectively with teachers, parents, administrators, and students with disabilities. It will focus on more frequently-occurring disabilities and the student characteristics with which you will most often be faced. The goal is to "put you in the driver's seat" in terms of managing those duties as defined by federal law and identified by professional organizations such as the American School Counselor Association.

School counselors today must demonstrate not only that they are proficient with counseling skills appropriate for typical learners but also that they can also work with students with disabilities. They must understand and address the social, emotional, and behavioral needs of atypical learners within the context of school law and school environments.

This first chapter provides a brief historical and foundational perspective about students with disabilities as determined by federal guidelines that define how students qualify for special education and related services. It also describes multidisciplinary teams and why they are important. Finally, it introduces the broad concept of how schools are federally mandated to respond to students with disabilities and school counselors' unique contributions to this collaborative effort.

The New IDEA

Children with disabilities include those with a wide range of physical, cognitive, behavioral, and emotional handicaps. Such students have varied educational, social, and emotional needs. In an attempt to meet these needs, schools often place these students in special education classrooms for part or nearly all of their school day. The Individuals With Disabilities Education Act (IDEA), passed in 1990 and reauthorized in 1997, requires schools and all school personnel to provide appropriate education in the least restrictive environment for children (birth through age 21) with disabling conditions. Many counselors will think, "I wonder if this is what I used to know as P.L. 94-142?" The answer is yes. Basically, the new law was written to reflect a healthier emphasis on the person first and disabilities second.

The intent of the Act is to guarantee a free and appropriate public school education to all students, regardless of the type or severity of their disabilities. Over the years, a variety of special education class placements have been created to help develop the full human potential of students with disabilities. Placement options ranging from

total institutionalization to integrated education in the regular classroom (mainstreaming) have been used. This Act entitles eligible students to appropriate evaluations by qualified professionals, which include school counselors. A variety of assessment procedures must be used, and these procedures must be as free as possible from racial or cultural bias. Parents must give informed consent before their child is evaluated or reevaluated.

Due to the implementation of the Individuals With Disabilities Education Act (1990), more children with disabilities have been educated with children who are nondisabled. At one time, the best practice suggested that children with mild learning problems be educated in the regular classroom, whereas those with more serious problems were thought to be better served in a resource room or outside of the regular school environment. More recently, this belief has been challenged, and there is a movement to get more students with special needs back into the regular classrooms with their nondisabled peers. Such challenges speak to the concept of "least restrictive environment," which is another legal aspect of IDEA. Regular Education Initiative (REI), or full inclusion, is now the goal of many educators and parents leading the special education reform movement.

A director of special education has pointed out that one of the challenges of the concept of full inclusion is that it runs contrary to the federal mandate to provide a continuum of services. What the law says is that the regular classroom is the best place for all children unless their disabilities are so severe that, even with accommodations, success cannot be achieved.

The counseling implications of REI are many. First, school counselors may be asked to provide behavior management programs for several children because regular education teachers may not feel equipped to handle the social/emotional deficits that some children may exhibit. Another counseling implication is that, because many kinds of children are in the regular education classroom, the school counselor will have to modify his or her classroom guidance activities. Finally, the school counselor may need to provide more consultation to those teachers with students who have special needs that relate to their affective, social/emotional, or cognitive development.

IDEA includes children and youth with the following specific disabilities as eligible for services, if the disability is determined to interfere with academic progress:

- Mental retardation
- Hearing impairments
- Specific learning disabilities
- Speech and language impairments
- Orthopedic impairments
- Serious emotional disturbance
- Autism
- Traumatic brain injury
- Visual impairments
- Other health impairments

Some school administrators appear to believe that only children with cognitive disabilities are eligible for services. Whether this reflects an attempt to save money or a genuine misunderstanding, it is far from the truth. Cognitive ability is only one of several areas in which a child can qualify for services. For example, in one midwestern state, a school denied access to special education services to a student who had a well-documented record of significant behavioral problems and aggression. This student was diagnosed with depression and conduct disorder, but because the school found no learning disability, the student was denied services. Lawsuits brought by parents in cases like this have been successful.

One important and interesting thing to note about eligibility is that a student who has inadequate or interrupted previous education or limited English proficiency cannot, on those bases alone, be considered to have a disability. For example, the child of a migrant worker may have both of these conditions, and may be struggling in school, but could not accurately be labeled as having a disability. Of course, this does not mean that you will not work with these students as part of your regular duties, but they will not necessarily be involved in special education.

Section 504

Section 504 is a section of the Vocational Rehabilitation Act of 1973 that is commonly known as the "civil rights law for the disabled." In order to be eligible for 504 status, a student must have documentation of physical or mental impairment that substantially limits a major life activity, such as walking, seeing, hearing, caring for oneself, performing manual tasks, breathing, learning, speaking, or working. This law says that no one should be excluded, on the basis of a disabling condition, from any program or activity receiving federal support. Most schools receive federal dollars, so they must comply with this law.

Examples of possible 504 disabling conditions that are *not* typically covered under IDEA are the following:

- Communicable diseases (HIV, tuberculosis, etc.)
- Medical conditions (asthma, diabetes, epilepsy, etc.)
- Temporary medical conditions due to illness or accident
- Attention deficit disorder
- Drug/alcohol addiction
- Chronic health conditions

Any disabling condition that can be documented as interfering with a student's learning process may be considered for accommodation under Section 504. This eligibility differs from that under IDEA in that it focuses on equal access and eliminating barriers in the regular classroom. IDEA includes significantly modifying the curriculum, whereas 504 is about reasonable accommodation within the existing curriculum. For example, IDEA may require specialized instruction involving radical restructuring of the learning environment for students with disabilities. Section 504 has to do with allowing students with disabilities to participate fully in existing educational settings without major changes.

Appropriate accommodations for each student determined to be eligible under Section 504 are developed by the 504 team and the parents. Typically, the major responsibility for carrying out these

accommodations falls on regular classroom teachers. The student's progress, with regard to the goals and objectives spelled out in the educational plan, is monitored regularly by a 504 coordinator. The plan itself is reviewed periodically (the length of time varies from district to district) to make sure that the goals are still appropriate for the child. Many students who do not qualify for special education services may still qualify for consideration and accommodations under Section 504. Typical accommodations include air conditioning a classroom for students with severe asthma, voice-activated computers for students with orthopedic impairments, or one-on-one untimed testing for students with epilepsy.

The intent of the law is to allow all students to have an equal opportunity to benefit from and participate in services offered by the schools. Although the goal of this law is to prohibit discrimination on the basis of a disability, Section 504 *did not provide any federal funds* to support schools' efforts toward that end.

Three conditions must be met before a student can be considered for services under Section 504 of the Rehabilitation Act of 1973: the disability must be mental or physical, it must affect a major life activity, and it must be substantial. Most districts will require a medical doctor's evaluation to confirm this.

Case Study: Isaac

Isaac is a 7-year-old second grader with rheumatoid arthritis located primarily in his hands. Because there is not a significant discrepancy between his academic achievement and cognitive ability, Isaac's disability does not qualify him for special education services provided under IDEA.

Isaac has difficulty completing some school projects and is failing penmanship. He has difficulty participating in art and physical education and many times cannot finish tests at the same rate as his classmates. He was evaluated by the school psychologist and earned average to above average scores on the WISC-III. He was administered various achievement tests (Test of Early Reading, Test of Early Mathematics), and his scores fell within the average range. Because Isaac's physical impairment is limiting his participation in school

(major life activity) and this limitation can be documented, he is eligible for accommodations by the school district under Section 504 of the Vocational Rehabilitation Act of 1973.

The 504 team and the parents determined that Isaac would benefit from a laptop computer to assist him with written work and some art work. Occupational therapy would be added to help with fine motor development that directly intervenes with physical education and penmanship.

Specific Learning Disabilities

The number of children identified with specific learning disabilities continues to increase annually. The majority of cases of all students receiving special education services are identified as learning disabled, making specific learning disabilities the most common source of school-learning problems today.

The Association for Children and Adults with Learning Disabilities defines specific learning disabilities as chronic conditions of presumed neurological origin that selectively interfere with the development, integration, and/or demonstration of verbal and/or nonverbal abilities. Specific learning disabilities exist as a distinct disabling condition in the presence of average to superior intelligence, adequate sensory and motor systems, and adequate learning opportunities. Throughout life, the condition can affect self-esteem, educational achievement, vocational aspiration, socialization, and/or daily living activities.

In recent years, students with learning disabilities have been described more broadly by Sattler (1998) as those who, for some reason, fail to progress but possess normal intelligence, adequate maturation, an opportunity to learn, and adequate family support for learning. Most education specialists working in the area of populations with special needs consider *learning disabled* an umbrella term to include individuals who, for sometimes unknown reasons, have diverse learning problems.

What you might notice during small group or classroom guidance is that students with disabilities may appear inactive or overly active, passive, inefficient, or disorganized. Counselors need to pay attention to individual needs and differences, and should plan to include activities that engage students through all of their senses. Instead of just talking about how to get along with others, try role playing. When the topic is feelings, let students select felt symbols or words to express the emotions of characters in a story.

The literature suggests that the learning disabled population is extremely heterogeneous, with learning problems consisting of a number of distinct subtypes. Although one student with a specific learning disability in reading may exhibit low self-esteem and a degree of acting-out behavior, another who qualifies for services in exactly the same way may demonstrate no acting out or social-emotional problems.

Suzanne and Jay are both 10th graders with identified learning disabilities in the area of reading comprehension. Suzanne is shy and withdrawn, very conscious of her disability. She is at risk for dropping out of school, and when asked about it, drops her eyes and says softly, "School's not for me. I'm dumb." Jay, with the same diagnosis, is outgoing and confident. He is a varsity athlete and has such strong social skills that his learning disability was not confirmed until recently. He is concentrating on learning new coping techniques and is already looking at college catalogs. He likes to stop by the counseling office, stick his head in the door, and say with a grin, "I want to do what you do."

Counselors should remember that knowing that a child has a learning disability may not indicate that the child is a "problem student." And this example illustrates that knowing that two students have similar or even identical disabilities does not mean that they are very much alike.

However, the impact of learning disabilities on students is extraordinary. When you look over the facts below, remember that the vast majority of these students have average or above average intelligence. Think about what these statistics mean in terms of loss of human potential:

- The school drop-out rate for students with learning disorders is 40%.
- Thirty percent of the entire American population has some sort of learning disability.
- Of school-aged students, 10% have a learning disability.
- Relatively few students with learning disabilities go to 2-year colleges (12%) or 4-year colleges (4%), although this number is increasing as postsecondary institutions also are affected by ADA and IDEA.
- Only 16% of students with learning disabilities go to vocational schools.

When identifying a student with a specific learning disability, there are two basic criteria the student must meet. First is the academic component. The multidisciplinary team must find that a student has a significant discrepancy between academic achievement and intellectual ability in one or more of the following areas:

- Oral expression
- Listening comprehension
- Written expression
- Basic reading skills
- Reading comprehension
- Mathematics calculation
- Mathematics reasoning

The second criteria is the exclusionary component. The multidisciplinary team may not identify a child as having a specific learning disability if the severe discrepancy between intellectual ability and academic achievement is primarily the result of

- Visual, hearing, or motor handicap
- Mental retardation
- Emotional disturbance
- Environmental, cultural, or economic disadvantage

April is a 16-year-old Native American student who is new to your district. Teachers report that she seems "clueless" and can't keep up in the classroom, especially in reading. The school psychologist tests April and finds that her intelligence falls within the average range, but her reading comprehension is at the 6th-grade level. At first glance, it might appear that April has a learning disability; however, April was in school only 40 days her freshman year and skipped an entire semester the following year. Therefore, the discrepancy that exists between her intellectual ability and her achievement level in reading is most likely to be a result of her extensive truancy rather than a neurological condition.

Federal regulations delineate procedures that schools must follow when identifying students with specific learning disabilities. Initial efforts on the part of school staff members to help a student who is having problems succeeding in school are called *prereferral activities*. These might include a reinforcement plan for on-task behavior or consistent verbal praise for behaviors that have been targeted as in need of remediation.

The school counselor oftentimes is a member of the Teacher Assistance Team, sometimes referred to as the Child Study Team, and will participate in planning and carrying out interventions before a student is formally referred for a psychoeducational evaluation. A student may be struggling either academically or behaviorally and has been brought to the attention of the school counselor. The counselor may work with the student for a few sessions to try to discern the exact nature of the problem and offer the student small group or individual assistance.

If the interventions suggested by the Child Study Team meet with no success, the next step is typically to call on the school psychologist, speech and language therapist, and occupational and/or physical therapist to provide assessment to determine if there are any developmental delays, specific learning problems, and/or social-emotional problems. School counselors may be asked at this point to conduct observations or provide anecdotal accounts of the contact they have had with the student. If these efforts are determined to be unsuccessful and, after referral and evaluation, it is seen that the student is eligible for services under IDEA, a multidisciplinary team is created.

The School Counselor as a Member of the Multidisciplinary Team

School counselors are often the first people with whom concerned parents communicate, and they are in favorable positions to work closely with all individuals providing assistance to students with special needs. Consequently, school counselors will find that their participation as identified service providers to students with special needs and their families will continue to grow.

How and why school counselors get involved in either identifying or working with a student who has special needs differs from case to case. But, for various reasons, counselors are increasingly being asked to join multidisciplinary teams in the schools and need to be prepared to take a meaningful and appropriate role.

Multidisciplinary teams are mandated by IDEA when identifying students with special needs. Team members *must* include parents, classroom teacher(s), the special education teacher, a school psychologist (or an individual who can interpret evaluation results), an administrator with the authority to make decisions, and *may* include the speech and language clinician, a physical and/or occupational therapist, a school counselor, and other professionals (e.g., administrators, physicians) at the discretion of the school or parents. The student is included whenever appropriate. Together, members of the team pool their assessment results, both formal and informal, in order to make decisions regarding appropriate services for students.

Collaboration should be a highly valued part of the IEP process. Collaboration is much more than coordinating services or cooperating with various stakeholders. Collaboration requires each participant to be willing, if necessary, to give up a piece of his or her professional "turf" or control for the larger good of the goal—student success. The idea of a collaborative multidisciplinary team assumes that all participants and their opinions and data are of equal importance. Each member shares in creating and being accountable for the goals of the student.

Experience and research suggest that school counselors have been either overinvolved in multidisciplinary teams by acting as case managers, or underinvolved by not interacting with any students

identified as having disabling conditions. An appropriate balance for counselors working with students with special needs is outlined in the American School Counselor Association (ASCA) position statement. The role and responsibilities of the school counselor, as endorsed by the ASCA, include services for students with special needs. Moreover, school counselors are legally required to meet the educational needs of students with disabling conditions. IDEA prohibits the exclusion of students with disabilities from developmental guidance and counseling services. The truth is that because of certain disabling conditions, identified students may need additional and specialized services from school counselors.

The School Counselor and IDEA 1997

ASCA's (1993) position statement with regard to IDEA (adopted 1980; revised 1986, 1993) asserts that "it is particularly important that the role of the counselor in these procedures is clearly defined and understood by all concerned." The basic tenets of the statement as revised are paraphrased here. According to ASCA, school counselors should do the following:

1. Assist in identifying students with disabling conditions and securing informed parental consent for referral to the multidisciplinary team
2. Serve as a member of the multidisciplinary team in order to determine the most appropriate educational services with regard to counseling and affective issues for children with disabling conditions
3. Provide supportive counseling for parents
4. Provide guidance and counseling services to students with disabling conditions consistent with those provided to students without disabling conditions
5. Consult with multidisciplinary team members on the educational and affective needs of students with special needs

6. Assist in developing and implementing staff inservice programs with regard to counseling issues for these students

Just as important, ASCA believes that the following responsibilities should *not* be carried out by the school counselor:

1. Serving as the school's one representative in preparing IEPs in areas other than guidance and counseling
2. Making decisions on student placement or assuming a supervisory role
3. Working on a multidisciplinary team for students not part of the counselor's caseload

Concluding Comments

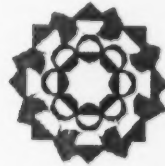
This chapter defines which students are covered under the legal mandates for special education services and how eligibility is determined. To be able to determine this, counselors need a basic familiarity with IDEA as well as Section 504. A brief overview of how students with disabilities are handled in schools, from isolated resource rooms to full inclusion or mainstreaming, is also included. Information on learning disabilities and their impact on students show that there is a lot of room for counselors and other professionals to make a significant difference in the lives of students with these disabling conditions. The unacceptably high dropout rate coupled with low career achievement of these students indicate that society is not served well if their needs are not met early in school. Approximately 5 million students (12%) in the public schools are identified as children in need of special education services. This is a significant and growing number that school counselors will be called on to serve. The following list describes basic characteristics of counseling programs committed to effective inclusion.

- School counselors are committed to the principles stated in the ASCA position statement.

- Regular collaboration between home and school not only helps the student, but encourages all parties to do what is best for the student.
- Whenever possible, students themselves are to be involved and identified as responsible for carrying out the stated objectives.
- A system is in place that allows school counselors to assist families in receiving other available resources.
- Students with disabilities are included as often as possible in classroom guidance activities and small psychoeducational group activities.
- Students are regularly assessed for developmental appropriateness of instruction and counseling interventions.

2

Knowing the Whole Child



You're attending the spring concert at the middle school and marveling at the range of normal development displayed on stage before you. Some boys sing bass while some still sing soprano; and there are still the self-conscious few whose voices betray them by cracking during every chorus. Some of the young men look as if they are still in the third grade and others look like they have been shaving for years.

Among girls, the diversity is just as striking. Listen to a group of fourth-grade girls decide how to spend an unscheduled Saturday afternoon. Some of the girls will happily play school or Barbies while others will want to focus completely on dating boys and practice their already-adept skills at applying makeup.

All of these behaviors fall within the normal range of child and adolescent development. But clearly atypical behavior or development, such as that evidenced by the student who is always alone at

lunch or on the playground and not involved in any school activity, or one who has consistent acting-out behaviors in the classroom, might be seen as having a developmental issue needing attention. Identifying these areas in need of remediation will be much easier to recognize when typical child/adolescent development is well understood and considered. This distinction is not always an easy task, but one that is necessary when determining how to best intervene in the life of children and youth.

Gathering Data

Using various assessment techniques, school counselors should be able to identify deficit areas, such as low self-esteem, inadequate social skills, or impulse control, as these problem behaviors relate to educational performance. Parent-rating scales, teacher-rating scales, behavioral observations, structured interviews, and family assessments are practical tools that school counselors can use when identifying specific areas that require remediation. Documenting the results of these assessments is important because it helps in the initial phase of the IEP process. First, deficit areas must be identified and described in terms of the present level of performance and the impact on educational progress. Once the curriculum areas affected by the disability are identified, an effective plan for counseling and other interventions must be created.

Often, background data will have been provided by the school psychologist and/or classroom and resource room teachers. This information will be extremely helpful when constructing counseling goals and objectives. It is also always good practice to gather information through direct observation, self-report inventories, rating scales, checklists, and interviews to help make any counseling decisions. There are many formal and informal assessment tools school counselors can call on to help with identifying student problems. These will differ, depending on the nature of the problem, and by whom and how the referral was made. We suggest uncontrolled or naturalistic observation as a first step, followed by either a structured or semistructured interview.

Sattler (1998) has recently authored an exemplary book that provides school counselors with all of the necessary "do's and don't's" of conducting high quality intake interviews with students and their families. General principles and techniques of interviewing—encompassing children and families of color; children with psychological, behavioral, or emotional disorders; and children with disabilities—are included. Several fully structured interviews are also presented in their entirety.

A final step to ensure a thorough assessment of social/emotional and behavioral functioning is to administer a self-report inventory, behavior rating scale, or checklist to gain additional standardized information. Most school counselors will have the requisite training to administer and interpret these various assessments. Master's-level counselors typically qualify to purchase, administer, and interpret both level A and B testing materials. What is most important about assessment is that the examiner has had appropriate and relevant training, experience, and supervision before using any of these resources.

If it has been some time between observations or administrations of various rating scales and checklists, remember to carefully study all procedures and the psychometric properties. Counselors should frequently review tests and other assessment materials in order to be thoroughly familiar with them before using them to determine treatment for a student. If you feel uncomfortable using new instruments on the market, your district's school psychologist may agree to work with you to help ensure proper administration, scoring, and interpretation. The list of self-report inventories, rating scales, and behavior checklists in Table 2.1 includes those commonly used by school counselors.

The Achenbach Behavior Checklist is a highly respected instrument that measures various social problems and perceived academic competency in various behavioral domains. This tool includes parent, teacher, and youth report forms and, in our experience, has proven to be extremely useful to school counselors. An example will demonstrate how this assessment method can be used to identify

TABLE 2.1 List of Assessment Tools

<i>Evaluation Method</i>	<i>General Purpose</i>
Behavior Assessment System for Children	Measures behavior deficits and behavior problems
Behavior Assessment System for Children—Student Observation System	Assesses behavioral and emotional functioning
Behavior Problem Checklist (Revised)	Identifies problem behaviors in children
Child Behavior Checklist	Evaluates behavioral problems in children
Child Behavior Checklist—Direct Observation Form	Assesses behavioral and emotional functioning
Child Depression Inventory	Assesses level of depression
Connors Rating Scale	Identifies attention deficit disorder/behavior problems
Family Environment Scale	Assesses child/parent perception of family environment
Piers-Harris Children's Self-Concept Scale	Measures self-concept through self-report
Reynolds Adolescent Depression Scales	Measures symptoms associated with depression
Social Skills Rating System	Measures social skills in different settings
The Student Self-Concept Scale	Measures self-image, academic and social self-concepts
Vineland Adaptive Behavior Scale	Measures level of personal responsibility and self-care

problematic areas with a student, provide "present level of performance" information, and lead to defining long-term goals and short-term counseling objectives.

Case Study: Hannah

Hannah is an 11-year-old sixth grader who appears depressed. Teachers report that she seems listless, tired, and unmotivated in the classroom. A review of her grades over the past 5 years indicates that they are barely passing, except in math, where she consistently maintains a C average. According to Hannah's file, she was evaluated in first grade by the school psychologist, and it was determined that no learning disorder existed.

At this point, however, based on teacher and parent referral, the school psychologist was asked to repeat the testing again this year. Hannah's mother met with the school counselor and shared that she was worried about Hannah's low self-esteem and lack of friends. The mother also said that Hannah rarely invited friends over and was never included in birthday parties and other social gatherings. Teachers have been concerned about Hannah's social isolation as well, although she has never been seen as a "troublemaker" at school.

Hannah's emotional and behavioral functioning was assessed through the use of several assessment methods. The counselor agreed to administer the Child Behavior Checklist, both Parent and Teacher Report Forms, the Piers Harris Children's Self-Concept Scale, and to conduct a direct observation as well as a structured interview.

As mentioned earlier, when assessing a student who has been referred for behavioral or social concerns, documentation of your findings is vital to the IEP process. The data you collect can be used to answer all of or part of the "present level of performance" question. The report is simple to put together and will provide you with necessary documentation. To begin, identify the student, his or her date of birth, and the dates your assessment took place. You might want to make a general statement about why the student was referred to you, state the assessment results in understandable terms, and include a brief summary. Following is an example of a short report describing Hannah's assessments.

BEHAVIORAL ASSESSMENT

Confidential: Professional Use Only

Name: Hannah

Date of Assessment: 11/23/98

Date of Birth: 07/04/87

Grade: 5

Reason for referral: Hannah was referred for a behavioral evaluation by her parents and classroom teacher. Areas of concern include Hannah's lack of attention to task, social isolation, tiredness, and lack of concentration.

Results: Hannah's behaviors as they are perceived to occur within her home environment were rated by having her mother complete the Child Behavior Checklist. This behavior rating scale is a checklist with 113 items that provide a profile of Hannah's behavior as reported by her mother (see Table 2.2). A three-point scale is used to rate the items.

Results of the CBCL indicate that Hannah's withdrawn behavior, social problems, and somatic complaints are clinically significant. The anxious/depressed scale symptoms are approaching clinical significance. Hannah's mother's report on the CBCL is reinforced by the results found on the Teacher Report Form.

The Teacher Report Form is a behavior checklist with 113 items that provide a profile of behavior problems, adaptive functioning, and school performance for children and youth 5 to 18 years old. Hannah's behaviors as they are perceived to occur within her school environment were rated by having her classroom teacher complete the Teacher Report Form (see Table 2.3).

As Table 2.3 indicates, Hannah's classroom teacher sees her as having symptoms that point to childhood depression. She scored Hannah very high on withdrawal behavior, attention problems, social problems, and anxiety/depression.

TABLE 2.2 CBCL Parent Report Form: Results for Hannah

<i>Problem Scale</i>	<i>T score</i>	<i>Percentile</i>
Withdrawn	70	99
Somatic complaints	71	99
Anxious/depressed	68	96
Social problems	75	99
Thought problems	50	50
Attention problems	51	53
Delinquent behavior	57	75
Aggressive behavior	50	50

TABLE 2.3 Teacher Report Form: Results for Hannah

<i>Scale</i>	<i>T Score</i>	<i>Percentile</i>
Withdrawn	73	99
Somatic complaints	62	88
Anxious/depressed	73	99
Social problems	71	98
Attention problems	70	98
Thought problems	57	75
Delinquent behavior	56	73
Aggressive behavior	52	58

Piers-Harris Children's Self-Concept Scale:
The Way I Feel About Myself

Hannah also completed the "The Way I Feel About Myself," a self-report inventory designed for children and youth. Hannah indicated that she does not see herself as popular or attractive. She perceives herself as being a bad person and the reason her family has troubles. She responded that she worries a lot, is lonely, and feels left out of peer activities. She also indicated that she cries often and does not sleep well.

Behavioral reports such as these do not take much time to work up, and they provide you with important documentation and can relate the message that you are a professional and are not just "shooting from the hip." You will take the behavioral report with you to the initial meeting of the multidisciplinary team and will have the

documentation necessary to answer questions concerning how the student is functioning right now. The school psychologist will bring the results of his or her recent testing, which may indicate that Hannah has a learning disability in the areas of reading comprehension and written expression. Your data, along with that of the psychologist and others involved, will provide the information base for the construction of effective goals and objectives for Hannah. Her depression, social isolation, and learning issues will be addressed, and her chances to be happier and more successful in school will increase.

Concluding Comments

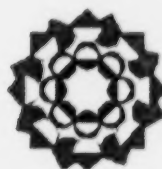
Using and understanding a variety of formal and informal assessments is a key part of the school counselor's role. When you took your appraisal and testing classes in graduate school, you may have been one of those who hoped that this area of responsibility would fall on someone else's shoulders in your work setting. But with the increasing numbers of students who have learning and behavior problems in school, assessment activities by school counselors are growing by leaps and bounds. Any good school counselor needs to be able to do effective assessments.

The assessments listed in this chapter do not comprise an exhaustive list, but do include those commonly used in schools. Test publishers often offer sample kits at little or no charge. You might want to assemble a collection of tests that look promising to you and go over them to see if they'd work well with your student population.

Also, strongly consider making assessment your area of focus for continuing professional education. Encourage your local, state, or regional professional association to include experts on the latest assessment techniques and tools in their conferences and newsletters. Ask your school district to sponsor inservice programs for area counselors on this topic. If you are really ambitious, try to become the local authority on social/emotional and behavioral assessment. Teaching and consulting with others is a great way to keep yourself up to date. It will also help you stay optimally effective with your students.

3

*How to TREAT Students With Disabilities**



The assessment strategies described in the previous chapter provide basic information to bring to staffings. This chapter introduces a comprehensive framework to help counselors conceptualize and operationalize their work with students who are found to be eligible for services. A special chart outlining this framework is provided for you to use as a handy reference on your desk or bulletin board (see Figure 3.1).

Once you have implemented the model a few times, you may discover that it gives a convenient and workable structure to what you already do. In addition, you will find this approach extremely useful in your individual counseling with all students, not only those

AUTHORS' NOTE: This chapter is adapted from Roberts, R. L., and Baumberger, J. P. (in press). T.R.E.A.T.: A model for constructing counseling goals and objectives for students with special needs. *Intervention in School and Clinic*. Used with permission.

The TREAT Model

Theories and Concepts

Relationships

Environments

Adjunct Services

**Treatable Goals and
Objectives**

Figure 3.1. The TREAT Model

J. P. Baumberger & R. E. Harper, *Assisting Students With Disabilities*. Copyright © 1999 by Corwin Press, Inc.

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who receive special education. Another payoff can be seen in terms of counselor accountability. The model provides counselors with a record of their work and evidence that they have met the *minimum standard of care*.

Because the growing array of problems confronting all students today (e.g., risk-taking behaviors, changing family structure) represent additional barriers to students with disabilities, developing realistic goals and objectives is always a challenge for the IEP team. In response to these problems, an important issue to consider is matching the intervention to the problem (see list of supportive articles in reference section). Because of the complex problems faced by students with disabilities, choosing effective interventions that match the presenting problems is a daunting task. School counselors must take into consideration all of the important treatment dimensions that are sometimes overlooked. These include sociocultural, environmental, relational, and support system characteristics.

A planning model can be a useful tool when attempting to work with all of these categories of information. The TREAT model is a mnemonic device that guides the writing of goals and objectives toward defensible, realistic, and manageable interventions in five critical areas. These areas are:

- Theories and concepts
- Relationships
- Environment
- Adjunct services
- Treatable goals and objectives

To use the model properly and most effectively, school counselors must address the areas in the sequence in which they are introduced.

Theories and Concepts

The first area, "Theories and concepts," asks the question, "How do I conceptualize the student's situation?" In other words, what theory of human behavior tells me what to pay attention to with my

students, as well as what I can safely ignore? Counselors are trained to use various theoretical orientations when helping students. These approaches may be based on one theory of counseling or may be eclectic in nature. Whatever the approach, it is essential that counselors begin with a conceptual model that guides their understanding of students and their problems. However, though important, theory is not the only part of the conceptualization process.

Larry Beutler and Mark Harwood (1995) believe that at least three important personal characteristics need to be considered when creating the treatment plan. They are:

1. Problem complexity: Is the problem unidimensional or multidimensional? Does the student have a learning disability only, or a learning disability complicated by attention deficit disorder and childhood depression?
2. Interpersonal resistance: How open is the student to external influence, especially from adults? Will the student be a reluctant or resistant client?
3. Coping styles: How has the student attempted to solve problems in the past? Does he or she internalize by compartmentalizing or externalize by acting out?

Each of these trait-like characteristics should be carefully reviewed and considered when creating goals and objectives. It is easy to see that students with different coping styles will require different counseling approaches.

Another issue to consider with regard to problem conceptualization when working on the intervention plan is the student's level of motivation. The degree of student motivation has a major impact on other aspects of treatment, such as whether restrictive placement is appropriate and who should assist in helping. In other words, the lower the student's motivation, the higher the probability that restrictive placement and additional adjunct services will be used.

Case Study: Cody

Cody is a seventh grader who repeated the third grade. He falls within the lower range of average intelligence and has been identified

as having a specific learning disability in the areas of mathematics and written expression.

Teachers and parents report that Cody is extremely difficult and draining to be around because of his endless negativity, passivity, and hopelessness. He has a history of self-inflicted abuse. The multidisciplinary team is requesting that the school counselor provide some sort of intervention to get Cody motivated in any area of his life.

Because Cody appears completely unmotivated, it may be necessary for him to spend a large portion of his day in the resource room. This will allow him to have much more individual attention from staff members. One of the goals of this kind of assistance is to have someone on the staff build a close relationship with Cody so that Cody's areas of interests and ability can be more easily identified. For example, a classroom teacher might view Cody's constant looking out the window as a lack of motivation and a short attention span. In fact, it may be that Cody has a high interest in cars and would love to learn how they work. This may be one of his few interests, and once it has been identified, this interest can be used to further motivate Cody. Reading and math assignments involving auto mechanics may change Cody's attitude toward learning. Rewards for good behavior in school could include time in the auto shop. Although auto repair may not be a core curriculum area, this subject may unlock Cody's defenses and provide a positive context for school success.

Examining these qualities of motivation, environmental issues, student strengths, and stressors when determining appropriate interventions may help avoid disappointing setbacks in meeting the objectives of the IEP.

Once the larger questions of conceptualization have been answered, three additional questions remain:

1. What is happening during school and nonschool hours (social, cultural, and other environmental concerns) for the student?
2. What strengths or stressors does the student bring to the counseling process?
3. And finally, how will these strengths enhance or stressors inhibit the student's meeting his or her objectives?

This information typically can be provided by the student, parents, teachers, and other school personnel.

The very last question to ask is whether additional medical or psychological testing is necessary. This will happen when conceptual questions cannot adequately be answered. At such times, school counselors may need to consider requesting additional medical or psychological tests such as The Children's Apperception Test, Millon Adolescent Personality Inventory, or Kinetic Family Drawing.

Relationships

The second major domain in the TREAT model concerns relationships. Just as in most counseling situations, the relationship between the counselor and student has a major influence on whether counseling will be successful. Because the relationship between student and counselor is so important, a critical question must be asked before counseling goals can be written: "Will this student work with me?"

Outcome research suggests that the student's active participation in the counseling process is critical to the helping relationship. Including student expectations as well as school and parental needs ensures greater success in meeting the identified goals and objectives.

Building relationships with students is no different than building relationships with anyone else. Genuineness, empathy, humor, gentleness, sincerity, and warmth are easily sensed and accepted by others. Children and youth are quick to note and appreciate unconditional positive regard, although they would never recognize the term. They also look for congruence between statements and actions, and can "sniff out" a phony fast.

One relationship-building activity that works well is to have students create or draw a "yellow brick road" of their lives on big sheets of paper. Ask them to use colorful markers to indicate important events that have occurred. This is not a one-sided activity; counselors participate by completing the activity, too. Children respond positively when counselors participate with them. When counselors disclose that "this is when my parents had a serious fight in front of me," children respect their honesty and sincerity. They can become more open about their own lives as well.

Case Study: Kelley

Kelley is a 14-year-old eighth grader. Her school records indicate that although she earns above average to superior test scores on standardized assessments, her academic progress appears to be erratic, with classroom grades fluctuating widely. The results of a complete psychoeducational evaluation indicate that no learning disorder exists.

Kelley's parents report that they believe the school is failing to intellectually engage Kelley. Furthermore, they believe that the quality of education at this particular school leaves much to be desired. When questioned about their daughter's academic work habits, they state that Kelley's homework is often incomplete and that her grades are, for the most part, unacceptable. They believe this is due to the fact that assignments and lectures have no meaning or importance to Kelley.

Teachers report that Kelley has constant excuses for her uncooperative attitude and lack of interest in school. They also describe Kelley as resistant, guarded, sarcastic, and hostile. When teachers have intervened with various behavior management programs, Kelley cooperates until she receives her reinforcement, and then returns to her normal pattern of behavior.

Kelley appears to be thoroughly convinced that she is doing fine in school. She also believes that there is absolutely no reason for her to either complete her schoolwork (she is smart and will learn it when and if she ever needs to use the information) or see the school counselor.

Do you know this kid? How will you go about building a relationship with her? Your role may be to give Kelley a "reality check" by using Glasser's Choice Theory. She may not realize that she, although bright, is in danger of not graduating. Have her review the graduation requirements and compare them with her own record. At least this may get her attention. In addition, she needs a different kind of relationship, one with a caring adult who is going to make her responsible for the choices she makes in school and the subsequent consequences.

According to research, the therapeutic alliance is more predictive of success than either technique or diagnosis. Often it is hard to

predict what kind of relationship you'll be able to establish before you actually begin to work with a student. However, obtaining information from teachers, parents, and other school personnel, as well as reviewing existing reports, can give you a pretty good idea of what is likely to occur in terms of the student's openness to working with you.

If you get a decisively positive or negative impression on this, it could be reflected in the goals and objectives on the IEP. You will need to document in the "present levels of performance" section, the student's openness to counseling, and then reflect that in the objectives. If the student is going to spend 2 months fighting the relationship, you may want to begin with a goal such as, "Kelley will respect the counseling process and see its benefits." Objectives that might lead to meeting this goal would read: "Kelley will keep counseling appointments six of eight sessions" and "Kelley will contribute to her counseling sessions by completing counseling homework assignments four out of five trials."

Counselors know that the higher the probability that both the student and counselor can align therapeutically, the greater the chance of successfully completing the IEP objectives and meeting the annual goals. On the other hand, the lower the probability for a good working relationship, the lesser the probability of successful treatment. This fact should be discussed in the IEP meeting in order to protect the counselor from being perceived as ineffective when, in fact, there is little hope of progress if the student refuses to respond to and work with him or her.

Other questions school counselors might ask regarding the therapeutic relationship include: Will the student agree to the goals of counseling? Can I care for this student? Can I be warm and empathetic? Is trust an issue with this student? The bottom line is to not take the counseling relationship for granted. Carefully consider the relationship's importance with regard to the student and his or her counseling progress; document your findings.

In cases where this relationship is clearly not going to work, counselors should put their energies where they will be most productive (with children and families who want assistance). In school counseling, "business is good," and there are far too many demands on a counselor's time to coax students to work with them.

Environment

A third major area of interest to the multidisciplinary team involves assessing the student's environment. Questions that are asked include the following: Where will counseling take place (i.e., school or alternative site)? What mode of counseling will be used (i.e., individual, group, or family)? How long will it take to meet the short-term objectives of the IEP? How often should the student meet with the school counselor or other helping professional?

It is important to answer the first question because, depending on the type, severity, and chronic nature of the problem, the school counselor may not provide the service. Students with issues such as suicidal ideation or severely self-destructive behaviors requiring restrictive placement might be referred to an in-patient setting, or, at the very least, a therapist who specializes in more severe behavior interventions. However, students requiring less restrictive environments (e.g., partial pull-out program) could receive services in the school counselor's office.

The mode of counseling must also be selected. Typically, in a school setting, the primary modes of counseling are individual, small group counseling, classroom guidance, or, depending on school resources, family counseling. Most school counselors recognize the need to vary the mode according to the nature and severity of the problem and the availability of support systems and resources.

Timing and intensity are the remaining elements that should be addressed within this domain. Again, problem complexity, problem severity, as well as school and student resources help the IEP team determine how often and how long counseling will take place. If the student with disabilities is experiencing or demonstrating a poor self-concept that interferes with learning, and he or she has an openness to working with the counselor on an individual approach, meeting 30 to 45 minutes a week for 8 weeks may be appropriate. However, with increased levels of problem complexity, the timing and intensity may need to be altered. Careful planning initially will help keep the student, school, and family informed and realistic about treatment progress. To as great an extent as possible, students and other stakeholders need to know when and what to expect so that fewer surprises await them in the course of intervention.

Adjunct Services

The fourth consideration in this model is adjunct services. These services are important because it is often difficult, and at times unethical, to provide counseling to a student without investigating alternative solutions. For example, Irina, age 15, has recently emigrated from Russia with her family. She is failing her classes because she does not read, speak, or understand English well. She has not had the time to make friends and appears lonely. However, she may not need counseling in a traditional sense. Instead, connecting Irina and her family with language classes in the community and support groups through agencies and/or churches may provide her with all the help she needs to become oriented and successful in her new environment. Another good idea is to pair Irina up with a peer helper who will assist her in becoming involved in organizations and other activities at school.

Adjunct services may include, but are not limited to, other mental health agencies, legal and financial services, support systems such as family, relatives, or close friends, and community support groups. A current and comprehensive referral system will expand available resources and increase the chances of meeting the counseling goals. Many communities provide a resource guide for caregivers and their clients. If your community has this directory, use it; if it does not, create one. Although *you* might not have time to do this, creating a directory would be an excellent project for peer helpers.

Treatable Goals and Objectives

The final domain in the model is "treatable goals and objectives." This area can be adequately addressed only if data are gathered under the first four areas. Failure to consider the variables outlined in TREAT can lead to oversimplified and unrealistic expectations. Expectations, when not met, can leave both the counselor and the student feeling defeated. The most common example of this is when school counselors rely too much on the relationships built with students and forget that relationships alone do not constitute professional interventions. Counselors who are good at relationships still

must conceptualize students and their problems, create strategies for effective intervention, and set attainable therapeutic goals.

If, in fact, all five areas have been addressed, then the school counselor can begin the task of writing the student's counseling-related goals and objectives. A case study at the end of this chapter illustrates how this model is applied, and a worksheet is enclosed for your use (see Exhibits 3.1 and 3.2).

Case Study: Jason

Jason was 15 years, 6 months old when his mother requested testing from his high school. She was concerned about Jason's poor grades and his frequent lying and stealing. She was also worried about his fighting, both in and out of school. Because of this behavior, he had been suspended from school three times so far this year.

Jason lives at home with both parents. His father works full-time as a postal worker and reports he is a recovering alcoholic who has been sober for 6 months. Jason's father also indicated that, although he had tried, he had never felt close to Jason because he had been "trouble from the beginning." However, Jason's father did say that Jason could "fix just about anything" and that he earned his own spending money working part-time at a gas station and garage.

Jason's mother works part-time at a grocery store and spends her free time assisting her elderly parents. She reports having no close relationships other than her parents, her husband, and Jason. She stated that Jason was a good boy, but that he had difficulty controlling his temper and that school had always been hard for him. They each report having trouble disciplining their son.

Both Jason and his parents state that he goes through frequent periods of depression, often lasting up to 3 or 4 weeks. At the time of the assessment, Jason reported significant periods of sadness that had begun approximately 2 weeks earlier. He had lost interest in school activities (wrestling and band), and he was not sleeping well.

On the Child Behavior Checklist, Jason's parents reported severe conduct problems. He had *T* scores of 79 on both the Delinquent Behavior and Aggressive Behavior scales. The severity of Jason's conduct problem was supported by his classroom teacher, whose responses also indicated Jason's behavior to be in the significant

EXHIBIT 3.1. TREAT Worksheet for Planning

T = Theories and concepts

1. How do I conceptualize the problem?
2. What diagnostic and nondiagnostic variables should be included in the treatment plan?
3. What sociocultural variables and accompanying coping resources are available?
4. Is additional medical or psychological evaluation necessary?

R = Relationships

1. Can a good working relationship be established?
2. Will this student work with me?

E = Environment

1. Where will the counseling take place?
2. What mode of counseling (individual, group, etc.) will be used?
3. How often will counseling occur?
4. How long will counseling continue?

A = Adjunct services

1. What additional services might benefit the student (e.g., mental health agencies; legal/financial services; support systems such as family, relatives or close friends, and/or community?

T = Treatable goals and objectives

1. Have the first four areas been adequately addressed?
2. Can I write appropriate goals and objectives?

EXHIBIT 3.2. TREAT Plan for Jason

T = Theories and concepts

1. Which theory/theories of counseling will I use to conceptualize the problem?
 - *Initial stage:* Person-centered counseling demonstrating warmth, empathy, and positive regard to counteract authority figure problem
 - *Working stage:* Cognitive behavior counseling focusing on Jason's self-defeating behavior and possible maladaptive thought processes (pattern of suspicious thinking)
2. What diagnostic and nondiagnostic variables should be included in the treatment plan?
 - Diagnostic*
 - Specific learning disability (reading and written expression)
 - Conduct disorder (fighting, lying, stealing, truancy)
 - Low self-esteem (external locus of control)
 - Depression
 - Nondiagnostic*
 - Substance abuse in the home
 - Overprotective mother
 - Long-term problem
 - Mother caretaker for elderly parents
 - Father known in community as alcoholic
3. What sociocultural variables and accompanying coping resources are available?
 - Parents and grandparents
 - Successful at part-time job
 - Member of the school band and wrestling team (B squad)
 - Strong mechanical abilities
4. Is further medical or psychological evaluation necessary?
 - Request alcohol/drug screening and depression assessment
 - Review cumulative file for psychoeducational history

R = Relationships

Can a good working relationship be established? Will this student work with me?

1. What kind of emotional bond is possible with this student?
 - Freshman and known only on paper
 2. Have we agreed on the goals of counseling?
 - Working alliance may be tenuous
 - Doesn't believe he has any problems but will come to counseling
 3. Is the student motivated?
 - Tentatively agrees to work on objectives in the IEP
-

EXHIBIT 3.2 Continued

4. Can I demonstrate empathy, warmth, and genuineness with this particular student?
 - Authority figure problems
 - Pattern of suspicious thinking
5. Is trust an important issue to consider with this student?
 - Critical but difficult

E = Environment

1. Where will the counseling take place?
 - School (counselor's office)
2. What mode of counseling will be used?
 - Individual counseling-cognitive behavioral counseling
 - Group counseling-interpersonal skill enhancement
3. How often will counseling occur?
 - Individual 30 minutes weekly
 - Group 50 minutes weekly
4. How long will counseling continue?
 - Varying duration dates stated within the IEP

A = Adjunct services

1. What additional services might benefit the student?
 - Suggest family counseling to address father's substance abuse
 - Suggest Alateen, Alanon, Alcoholics Anonymous
 - Counselor will encourage peer support through social skills group

T = Treatable goals and objectives

1. Have the first four areas been adequately addressed?
 - Yes, but each area will need to be revisited periodically to accommodate new information and therapeutic growth.
2. Write goals and objectives (see Chapter 4 for a detailed description of how to develop well-written goals and objectives).
 - Reduce acting out behaviors (impulse control)
 - Increase interpersonal skills
 - Reduce truancy and suspensions

Given Jason's history, goals may need to be closely monitored and restated so that Jason can experience some level of success from the counseling interventions.

range on the Delinquent Behavior scale and on the Aggressive Behavior scale. On the Piers-Harris Children's Self-Concept Scale, Jason's score indicated feelings of isolation and loneliness. A review of Jason's cumulative file indicates that he has averaged two suspensions per year since the third grade. The psychoeducational assessment revealed that Jason is functioning in the average range of intelligence (Full Scale IQ 109), and that he scored in a range considered significantly below his intellectual level on the Kaufman Test of Educational Achievement. These scores indicate that Jason has a specific learning disability in the areas of reading and written expression. The TREAT plan for Jason is shown in Exhibit 3.2.

Concluding Comments

The TREAT model is complex, and many readers may be tempted to simply use the more straightforward chapter on how to write good goals and objectives. But the authors encourage you to integrate this model into your counseling practice. It will help you come to IEP meetings with a strong rationale for your recommendations.

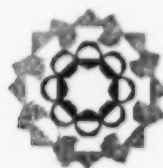
In an age of increasing accountability, schools are demanding that their school counseling professionals not only meet with students identified by multidisciplinary teams, but that they demonstrate the skills necessary to successfully work with students with a wide range of problems. This can be accomplished best by using a comprehensive model, such as TREAT.

This model, although not perfect, provides the multidisciplinary team, and specifically school counselors, with a procedure to systematically organize all relevant information when addressing students with disabilities. Use of this model results in measurable, manageable, and defensible goals and objectives.

Note: Your goals and objectives will be influenced by the way you conceptualize student issues. A systems-oriented counselor would look at Jason much differently than in the example given. From a systems perspective, Jason may be perceived as the family scapegoat. Interventions with Jason would then center on providing coping mechanisms that will help him understand the complex nature of the system he is living in.

4

Building a Structure for Success



This chapter provides examples of how school counselors can identify and carry out counseling goals that address social-emotional and behavioral problems that affect classroom learning. Each state has its own method of addressing federal criteria for working with students who have disabilities. You will want to talk with your resource room teachers and the director of special education to have them explain what your state requires with regard to documentation and proper completion of individual educational planning documents. And remember, all requirements will change

over time. Right now, only the law (reauthorized IDEA) has been passed; no implementation regulations are in place but they will be soon. Often, one of the first questions to be answered at the planning and placement meeting involves identifying the skill or curriculum area affected by the disability. Typically, for school counselors, this will involve the social/emotional, daily living skills, or academic/career guidance domains. For example, social competence is a commonly overlooked aspect of student academic success and social acceptance. Appropriate, well-developed social skills are essential for successful participation in school, work, family, and community.

When students experience significant social problems, learning and the quality of life are directly affected. If a student's lack of social skills is inhibiting his or her academic progress, then that should be identified on the IEP as the skill area affected by the disability. (Sometimes the skill area is referred to as the curriculum area affected by the disability.) A student does not have to be diagnosed as seriously emotionally disturbed to receive services in the areas of behavior management or social and/or emotional development.

Examples of good counseling goals in the social skills area include "Jeremy will decrease violent expressions of anger and frustration in the classroom" and "Erika will increase her ability to accept direction from adults in school." These goals are good because they are realistic and measurable. They also clearly address issues that relate to academic performance and progress. A baseline can be established, and improvement on these behaviors can be monitored.

The social dimensions of learning disabilities are well documented; childhood and adolescent social acceptance is a primary predictor of adult social and emotional adjustment. Recall from Chapter 2 that before you begin to identify long-term goals and short-term objectives, federal law requires that there is documentation of current levels of performance in the area(s) affected by the learning disorder. If this happens to be social competence, there are many ways to assess this dimension of student functioning. Behavior rating scales, counselor observations, and student, teacher and parent interviews are widely used. Once this has occurred, you are ready to develop the goals and objectives for your student and his or her family.

Writing SMART

Specific Goals and Objectives

Measurable Goals and Objectives

Action-oriented Goals and Objectives

Realistic Goals and Objectives

Time-oriented Goals and Objectives

Figure 4.1. Writing SMART

J. P. Baumberger & R. E. Harper, *Assisting Students With Disabilities*. Copyright © 1999 by Corwin Press, Inc.

Writing SMART Goals

Goals refer to desired outcomes stated in measurable terms. Objectives are the specific tasks or steps that facilitate reaching those goals. A helpful device often used in writing good goals and objectives is the SMART model (see Figure 4.1). This mnemonic device helps counselors remember an easy way to check the effectiveness of what they write in IEPs. The first two letters refer to two questions: "Are the objectives specific enough to avoid misunderstanding?" and "Are the objectives measurable?"

One way to make sure that the objectives are specific and measurable is to insert the phrase, *watch me be* (Mitchell, 1991) in front of the objective. This will help you determine whether the objective is clear and quantifiable. For example, "watch me be cooperative" is vague, but "watch me listen without interrupting" is specific and measurable.

Objectives should also include action-oriented verbs. Make sure that the objectives you write clearly communicate what the student needs to do to meet the objective. For example, "John will enter class independently, walking slowly and talking quietly, four of five observations, for three consecutive trials."

The fourth part of SMART reminds counselors to check that the objectives are realistic. This was the major theme of Chapter 3, and by answering questions regarding the first four areas outlined in the TREAT model, objectives will be not only realistic, but also effective.

Finally, are the objectives time-oriented? In other words, does the short-term objective contain a specific time frame for task completion? If school counselors are to adequately and responsibly meet the needs of students, these critical questions must be answered before goals and objectives are written. Specifically, you must address five questions central to creating objectives that are both measurable and, more important, manageable.

School counselors must be able to create their own goals and objectives if they will be responsible for their implementation. Many times, school counselors have shared that case managers, administrators, and resource room teachers have written counseling goals and have then "informed" counselors that they were responsible for implementation. One such occasion involved an IEP that read, "The

school counselor will see the student daily from 1:00 to 2:00 p.m. to increase self-esteem and decrease acting-out behavior." This schedule puts the counselor in an impossible situation! Legally, the school counselor is bound by the IEP. Ethically, the counselor realizes that working with an elementary child for an hour every day is not therapeutically sound and that many other children will go without services if one child is taking 5 hours a week of one-on-one counseling.

Be sure to write your objectives in such a way that they reflect sound therapeutic judgment. Rather than state that the counselor will work with Annie once a week for the entire school year, state that Annie will begin working with the school counselor once a week for 30 to 40 minutes. After the initial relationship-building stage of counseling, Annie will practice new behaviors learned in counseling at school and at home. Examples of how to write therapeutically sensible counseling goals are presented later in this chapter.

Duration of service is another element that must be addressed on the IEP. It is reasonable to expect that counseling goals and objectives will be reviewed frequently to reflect the therapeutic gains and goals met. Once short-term instructional objectives have been met, new objectives can be written to address another annual goal. The team can also call a meeting to write an addendum that dismisses the student from further counseling beyond that which students without disabilities receive.

Remember that counseling goals should relate to the overall mission of the school. Generally, this looks something like, "The role of the school is to educate students to become productive members of their community and overall society." Goals should be selected in terms of their achievability, involve remediation and not rehabilitation, and specify in measurable terms the intended counseling outcome. It is extremely important for the school counselor to understand and be able to explain the distinction between remediation and rehabilitation. As the federal law reads and continues to be interpreted, schools are not responsible for "curing" a student, but rather for remediating deficit areas that inhibit learning. Table 4.1 provides three general examples of present levels of functioning, goals, and short-term objectives in which the curriculum area or skill area affected by the disability is social-emotional. Although the

TABLE 4.1 Example of Goals and Objectives

<i>Present Level of Performance</i>	<i>Measurable Goals</i>	<i>Counseling Objectives</i>
Strengths: Based on teacher and parent reports, Sara draws and paints very well. Sara takes pride in her artwork. Needs: Based on counselor interview and parent and teacher behavior ratings, Sara has an attitude of hopelessness, loneliness, isolation, and a general sense of worthlessness. Based on observation, Sara withdraws and isolates herself in the classroom and lunchroom.	Goal One: Sara will initiate and engage in conversations with school personnel. Goal Two: Sara will decrease feelings of rejection and increase feeling of acceptance.	When given verbal greetings by school personnel and classmates, Sara will respond by giving a greeting back, three of four observations for six consecutive trials. During homeroom, Sara will informally talk with one other classmate on at least three separate occasions over a 1-week period. Sara will use positive self-statements when given the opportunity, four out of five observations for five consecutive trials. Sara will invite a peer to participate in a social activity once a week for three consecutive weeks.
Strengths: Parents report that Tommy takes very good care of family pets and does well in math. Needs: Counselor observation noted Tommy fails to take turns, talks out of turn, loses things, breaks classmates' pens and pencils.	Goal One: Tommy will decrease his number of destructive and impulsive acts and increase his number of positive coping behaviors.	During group role play, Tommy will identify destructive and impulsive behaviors of others, four of five observations for six consecutive trials.

Continued

TABLE 4.1 Continued

<i>Present Level of Performance</i>	<i>Measurable Goals</i>	<i>Counseling Objectives</i>
Strengths: Isaac is a good natured little boy and is extremely polite. He is one of the best math students in the third grade.	Goal One: Isaac will develop coping behaviors to block and delay impulsive behavior.	When Isaac becomes upset, he will catch himself and use one of three coping strategies he learned in counseling with 80% for 2 consecutive weeks. Isaac will correctly use self-instruction and self-monitoring when working on reading assignments 7 of 10 observations for five consecutive trials.
Needs: According to the CBCL and TRF, Isaac tends to become overwhelmed very easily. He has a specific learning disability. When redirected for acting impulsively (knocks over milk, pulls down the maps) he cries, pulls his hair, or pokes himself with a pencil.		

counselor may have been identified as the primary person responsible for carrying out the objectives, others can and should be charting observations. All parties (e.g., teachers, parents) can help to document that counseling techniques and interventions are or are not producing the behavioral changes stated in the IEP.

Career-Related Goals and Objectives

In the career area, counselors can be key to a student's success in the transition between school and work. Students with disabilities are at great risk for unemployment upon graduation. Figures as high

as 75% are cited when documenting the number of people with disabilities who are without work and unable to live independently.

IDEA is clear in its expectation that students with disabilities will receive effective assistance in preparing for productive adulthood. Because school counselors have expertise in career development, this is another area in which they can offer leadership. However, counselors need to know how different disabilities influence physical, social-emotional, and cognitive development.

Counselors must manage the sometimes delicate balance between encouraging realistic goals and discouraging unrealistic goals. Pete is a 10th grader who has cerebral palsy. He would like to become either a firefighter or a police officer. These careers require passing rigorous physical examinations that he may never be able to master. However, Pete may well be able to become a very competent dispatcher or 911 operator. In this way, he can be encouraged to work in the career area he finds exciting, but within a role in which he can become highly successful. You will need to be aware of alternative career assessments, prepared to modify your own career materials, and ready to assist students with interest surveys that are sometimes beyond their reading or comprehension level. The following case study is a brief example of how career development goals and objectives can be written into an IEP for a student with mental retardation.

Case Study: Molly

Molly is a 16-year-old girl with Down's syndrome. Molly is African American and, once she gets to know you, has a lively personality. Although she is shy, she cares about her appearance and especially likes jewelry. She likes to try different hair styles and colors of nail polish. She lives at home with her family. Molly is the youngest of three children whose parents both work outside the home. Molly's family is close-knit and she is accepted and loved.

Although she can stay in the public school until age 21, her parents are looking ahead to the time when Molly can move to a group home and hold a job with supervision. They are making contact with

appropriate resources and agencies in the community, and are active in planning her IEP's at school.

Molly is excited about learning how to earn her own money. She looks forward to leaving home sometime and living with other young people, with supervision. Molly's school counselor needs to be aware of issues beyond her developmental disability. Racial and gender issues may also influence her future. Molly's safety, as a friendly but naive young woman, will need to be addressed before she leaves school.

The counselor suggests this general goal: Molly will begin working on an appropriate career direction, with adequate knowledge to obtain and keep a job (with support as needed). The team agrees this is an appropriate goal for Molly and determines that the school counselor, the resource room teacher, and Molly's parents will all be responsible for carrying out the objectives. Table 4.2 lists Molly's goals and objectives.

Life-Skills Goals and Objectives

Students with disabilities will often need assistance in acquiring skills for living independently. These skills can range from learning how to set up a checking account to how to behave acceptably in public. People with certain disabilities suffer from discrimination and the judgment of others, sometimes simply for the unusual ways they conduct themselves. For example, a woman was arrested for public intoxication when her unbalanced gait was caused by a physical disability. Some disabilities, such as autism and schizophrenia, tend to scare people, and often the authorities are called to intervene.

Students with disabilities can display many kinds of unusual behavior. Some of these include head banging, rocking, clapping, making unusual noises, shadowing, running in circles, and picking at skin. In addition, due to frustration or inability to be understood, some students will throw violent temper tantrums.

School counselors will want to become familiar with this range of atypical behavior so that they can help teachers, students, and parents understand. There is a danger that these students will be

TABLE 4.2 Molly's Goals and Objectives

<i>Present Level of Performance</i>	<i>Measurable Annual Goal</i>	<i>Short-Term Objectives</i>
Strengths: Molly is interested in getting a job and eventually living away from home. Needs: Based on interviews with Molly's counselor and parents, Molly has only a basic understanding of the world of work. Through interviews, Molly appears to have unrealistic career goals and talks about becoming a rock star.	Goal One: Molly will participate in career exploration.	Molly will attend, participate, and complete all activities in a 6-week career exploration group. With counselor assistance, Molly will complete the Self-Directed Search Form E, the Pictorial Inventory of Careers Talent Assessment, APTICOM Interests and Abilities, or the Reading-Free Vocational Interest Inventory (R-FV11). Molly will tour at least two job sites and meet with people who do jobs she might be interested in and able to perform (e.g., food service, cleaning, manufacturing). When asked, Molly will be able to respond to work-related questions with 100% accuracy four out of five trials. For example, when given a work schedule and transportation schedule, Molly will state what time she must leave home to be at the work site within 10 minutes of the start time.

Continued

TABLE 4.2. Continued

<i>Present Level of Performance</i>	<i>Measurable Annual Goal</i>	<i>Short-Term Objectives</i>
Needs: Parents report that Molly has responsibilities in the home but has no knowledge of how to get and keep a job.	Goal Two: Molly will learn job acquisition skills	Molly will successfully complete (with counselor assistance) job application forms on six separate occasions over an 18-week period. Upon completion of the career exploration group, Molly will choose one of three careers she wishes to explore further and shadow for 1/2 day on two separate occasions over a 9-week period. Following instruction on job applications and interviewing etiquette, Molly will independently enter the work site and speak clearly four of five observations, two consecutive trials.

misdiagnosed as mentally retarded, emotionally disturbed, or tagged with another erroneous label. It is important to remember that although all children may exhibit unusual behavior from time to time, those with disabilities will perform them more often and with more intensity. You may associate these behaviors with emotional disturbance, but in fact many of them are seen in children with visual or hearing impairments, traumatic brain injury, and other disabilities.

Case Study: Henry

Henry is a 12-year-old sixth grader who is somewhat visually impaired and mildly developmentally disabled. He lives at home

with two older brothers and a younger sister. His father works long hours and his mother is a full-time homemaker. Henry loves his two cats, and spends a lot of time grooming them. His grandmother, who lives nearby, has taught Henry how to work with clay, which is his favorite hobby.

In the last 6 months, Henry has exposed himself on the playground and attempted to sexually self-stimulate in the resource room. Some classmates have begun to tease Henry about his behavior and others just avoid him. Henry is confused by these reactions and lack of acceptance. He does not understand that what he is doing is not socially acceptable. You, as the school counselor, notice Henry's increasing isolation. You also have concerns about the long-range implications for Henry as well as the other children in the school if this behavior is not addressed effectively and soon. Henry's annual review is scheduled for next month, and the resource room teacher has asked that the school counselor address this behavioral concern.

The counselor suggests this general goal to the multidisciplinary team: Henry will learn that self-stimulation is not acceptable behavior at school and will control his urge to masturbate. The team agrees this is a good goal for Henry and determines that the school counselor, the classroom teacher, the resource room teacher, and Henry's parents will be responsible for working on the objectives. Table 4.3 shows one way to correctly address this concern on an IEP.

Concluding Comments

This chapter has shown how SMART objectives are constructed. They must be specific, measurable, action-oriented, realistic, and time-oriented. Those who are responsible for implementing the objectives must be involved in creating them. It should become a common practice in the school setting for counselors, classroom teachers, resource room teachers, parents, and others to share this responsibility.

Guidelines and requirements for writing IEP objectives vary considerably and are, in any case, a challenge. Counselors should consult with others to obtain the most current format and style.

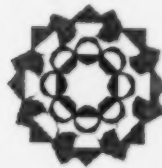
TABLE 4.3 Henry's Goals and Objectives

<i>Present Level of Performance</i>	<i>Measurable Annual Goal</i>	<i>Short-Term Objectives</i>
Strengths: Based on teacher and peer reports, Henry has a good sense of humor and is friendly.		
Based on teacher and peer reports, Henry touches himself inappropriately when he cannot get the attention of others right away or when he is reprimanded. Henry's resource room teacher reports that Henry self-stimulates when frustrated.	Goal One: Henry will increase appropriate physical touch of self and others.	When given physical prompt (e.g., touch on the shoulder) and verbal prompts, Henry will extend his hand to a familiar person (friend, classmate) for 3/4 trials for 4 consecutive days. When asked for a hug by family members, Henry will respond by gently hugging for 2 seconds or less, five of seven trials for 5 consecutive days.
	Goal Two: Henry will decrease inappropriate touching of self and others.	During counseling, when presented with enlarged pictures depicting people touching, Henry will be able to identify with 100% accuracy appropriate and inappropriate touch five out of five trials. When in play therapy using puppets, Henry will redirect the boy puppet to not touch itself or other puppets inappropriately, five out of five therapy sessions with 100% accuracy.

Remember that objectives must be therapeutically sound and fit within the overall mission of the school. Your expertise and creativity as a counselor will be tested when it comes to writing good goals and objectives!

5

Forming Partnerships With Families



Working with parents and families of students with disabilities can be both wonderful and challenging. We believe that students who experience social-emotional problems in school do so not in isolation, but rather within the context of the family and/or other social systems. The school itself is a system into which students bring the values, ideas, and interactional patterns of their family systems. Students with disabilities affect these systems and are, in turn, affected by them.

Both schools and family systems resist change and try to maintain balance or homeostasis. Just as people have roles in their families, they also have roles at school, and it is wise to remember that efforts to effect change may be ignored or even sabotaged. When thinking

from a systems perspective, it is vital to involve all members of the system when trying to make positive changes occur.

As all counselors know, parents (including legal guardians and surrogate parents) should be encouraged to participate as equal partners in their child's education. However, parents of children with disabilities often have distinct and significant reasons to be involved at school. These parents bring specific, valuable knowledge of their child's uniqueness. They also bring a longer-term perspective on the development of their child. For instance, a high school student experiencing attitude problems and struggling academically because of a head injury may be seen by the personnel in that school as suddenly combative and disrespectful. A visit with the parents may reveal adjustment issues dealing with grief due to the injury, a sense of powerlessness, and severe loneliness. This information sheds new light on the student, who then could be viewed more fairly and supported in more effective ways.

By law, parents must be included in all decision making regarding the special education needs of their children. Parental involvement is more than a courtesy, it is mandatory. Parents must receive written notification of any alterations in their child's regular education program, a procedural safeguard guaranteed to all families. These types of notification must be provided for any IEP meetings, reevaluations, or when a parent requests a due process hearing. The school counselor and the multidisciplinary team should view input from parents as positive opportunities. Parents, after all, have the highest stake in their child's success.

Families have tremendous influence on whether their children are successful at school. Working with and educating families is a good investment of a counselor's time and energy. Research supports the statement that parents who participate in guidance programs feel more positive toward the school and their child's education than those parents who do not participate. There is a positive correlation between family involvement and student success, regardless of disabling conditions. Therefore, school counselors can be the link for encouraging family involvement in the schools.

Getting the family "on your side" is half the battle. Parents are often just waiting for an invitation to become more involved in their

child's school. Questions counselors can ask themselves in this regard include the following:

- How can I help the families I work with feel like equal partners in their child's education?
- How can I help parents feel more welcome in our school?
- How can I help teachers and parents see the benefits of working together?

Power and Bartholomew (1987) have written about the following five types of school-family relationships:

- The avoidant relationship
- The competitive relationship
- Merged relationships
- The one-way relationship
- Collaborative relationships

Knowing about these types of relationships can help you identify and better understand the nature of the relationships you observe and participate in with families of children in your school.

There are many ways to look at family functioning. One way is to look at the family boundaries. When you work with families, you may want to ask questions that will allow you to discover whether the boundaries are rigid (very private) or diffuse (very open). Another quality to examine is the adaptability of the family. How does it handle stress or change? *Cohesion* refers to the "togetherness vs. autonomy" among family members. Disengaged families are said to have low cohesion; they may also be considered to be "separated" families. In contrast, connected families value family closeness but also allow each member some degree of independence. Enmeshed families have too much togetherness and members have difficulty functioning as individuals (Fenell & Weinhold, 1997).

Here is an example of what looks like enmeshment, but is not, taken from a local elementary school. During the winter, the younger brother of a boy who uses a wheelchair and has sensitivity to the cold

is seen as always playing with his brother on the playground before school and during recesses. The younger child adjusts the mittens, hat, and scarf of the older boy in the wheelchair; he never leaves his brother's side. When the bell rings, the younger boy escorts the boy in the wheelchair not only into school, but into the classroom, before going to his own class. The father of these boys calls the school every day to make sure that his son in the wheelchair is safely inside and in his classroom.

School staff might easily see this family as over-involved in the welfare of the child with the disability to the point that this child's independence and sense of self-reliance could be threatened. But is it enmeshment? Or has this family, as a result of a negative experience at school that left the boy in the wheelchair out alone in the cold South Dakota winter, found a way of managing the situation using its own resources?

Pipher (1996) advises mental health professionals to not be too quick to assume enmeshment and to not pathologize family closeness. In the situation described here, the school counselor should look carefully to see if the closeness is, in fact, inhibiting the development of the child. It seems more likely that the family is showing appropriate concern for a child they see as vulnerable, and taking care to make sure he is safe and warm.

Making Parents Feel Welcome

Unfortunately, many times parents feel unwelcome, intimidated, or even blamed when they attend meetings at school. Sometimes this is because the parents themselves had negative experiences when in school. For example, there is evidence that certain learning disabilities are inherited or run in families. Parents who were undiagnosed and perhaps seen as "problem" kids in their own day may relive feelings of frustration or inadequacy when coming back to the school setting to deal with their children's issues.

These individuals need to learn that they and their children are not "in trouble," and can help to create the best possible learning environment for the student. How different would it be at your

school if parent conferences were truly regarded as therapeutic rather than mandatory or even punitive?

If you notice negative parental feelings about school, suggest that parents bring a friend or another family member with them to the meetings. Be sure to frame your questions in positive ways whenever possible: "What would you like us at school to know about your child?" Use respectful language at all times (Mr., Mrs., Ms.) and refer to the student by name.

Parents will feel welcome at school if they are encouraged to visit and can, for example, stay for lunch with their child. If having parents present at certain times in the school day is disruptive, rules for these visits should be negotiated honestly and in good faith with parents.

Most parents of children with disabilities have an exhaustive history of efforts to help school personnel understand their children's needs. They are likely, in fact, to have had some unpleasant experiences when pushing for the best possible school environment for their child. They may have experienced active or passive resistance on the part of teachers and principals, or they may have perceived resistance in cases where there was only misunderstanding. It is good to remember that these parents often feel, for good reasons, that they are the only true advocates for their child.

One source of common misunderstanding and conflict in this area is that schools are required to provide only an appropriate education for the child, not an optimal one. Parents, quite understandably, want the very best, whereas schools have limited resources to meet the needs of all students.

Counselors can be pivotal in establishing good working relationships and mutual trust among parents and school personnel. First of all, they can be the ones who explain the process to the parents. Parents often receive only a brochure or folder of confusing material before coming to their first IEP meeting at school. This, obviously, is not a good way to build an open, trusting relationship. Many parents may arrive with the feeling, "Should we trust you?" or "Can my child succeed in this school?" Often, their experiences with schools have made them pessimistic. One of the roles of the school counselor is to acknowledge and address the legitimacy of parents' frustrations.

Lockhart (1998) suggests using Jay Haley's model for Strategic Family Therapy in running IEP meetings. To do this, begin with a social phase designed to reduce tension. Second is a process phase to inform everyone of the goals for the meeting. This is a good time to mention the Family Education Rights and Privacy Act (FERPA; Family Compliance Office, 1974), which states that parents have the right to a copy of any information shared in writing with another school staff member. Many parents do not know about this. Counselors should be careful what they put in writing, because parents can request copies at any time. Counselors' notes become a legal document that can be subpoenaed in later court action.

The third stage is the problem stage. At this point, all meeting participants give their perspectives on the situation while others listen. Questioning is not encouraged until everyone has had a chance to speak. Fourth, the group discusses what has been presented and gets clarification where necessary.

In the fifth stage, the team develops an appropriate plan for the student, capitalizing on his or her strengths and addressing areas of need. Finally, in the sixth phase, tasks for meeting the goals and objectives are assigned. Consensus and mutual respect are sought throughout this process.

Earning Parents' Trust

What can counselors do to earn the trust of parents? Treat parents of children with disabilities as normal people with a full range of strengths, weaknesses, and resources who are also trying their best to manage with a child who is disabled. It is important to prepare for each meeting, to try to anticipate parents' questions, and to have educational options and referral resources at hand. Specific suggestions of what parents can do at home to reinforce their child's success at school are valued.

As in any counseling situation, establishing rapport is vital. In order to build trust with parents, school professionals should show acceptance and give opportunities for them to share their extensive

knowledge of their own child. School-related information should be presented honestly and kindly, and, if possible, without using any kind of jargon. Many parents do not know, for example, what standard scores are, so reduce the use of technical language and explain how their child did on the assessments in plain language.

Remind parents that you will be there as an ongoing resource and that they can call with questions at any time. Parents often find IEP meetings overwhelming and depressing, and will greatly appreciate being able to call later to get clarification about questions that occur to them once the meeting is over. In fact, counselors should plan to initiate such calls instead of just saying, "Call any time." Periodic contact with parents to ask how things are going, what they have noticed, and similar questions will help build a good working alliance with the family. Calling parents when "something goes right" is really appreciated ("I noticed today that Amy sat still and was quiet during assembly. She seemed to enjoy the presentation by the veterinarian. I wonder if she'd like some books on working with animals?")

Feedback forms that can let parents express their level of satisfaction are helpful. Surveys of parent needs can help prioritize uses of resources. Counselors can use e-mail and voice mail to communicate with many parents. However you do it, establishing a reliable communication system is vital and will increase parental involvement.

Parents can be encouraged to pursue active roles in several ways. Harry (1992) has written that parents are the first assessors of their children with disabilities. When the family has a different language or even dialect from the school professionals, parents become "translators" for their children's needs. Parents can present reports at meetings, just as other participants do. Parents can also have input on policy making at the local level and beyond. Parents are obvious advocates and sources of support for each other. Some parents may even be interested in being part of research studies. All of these roles build parent involvement as well as deserved recognition of their competence.

Counselors often lead parent education groups, but again, the needs of parents of children with disabilities can be unique. Often, families are involved in planning and implementing behavior modification programs for their children. Counselors can be key in teach-

ing parents to select and use appropriate techniques, such as the following:

- Consistent consequences
- Clear directions
- Parent-child play or projects
- Relationship building
- Time outs
- Behavior extinction
- Positive communication skills
- Other cognitive behavioral techniques, such as the "stop, think, and plan" method of helping the child solve his or her own problems

Counselors can model positive communication for families, teach the family new ways of interacting, and provide helpful feedback. Counselors can also help parents focus on their child's strengths rather than deficiencies.

Adapting Your Style

How would your style change if you incorporated more of a systems perspective? How could you integrate this perspective with your own theory and practice of counseling? For example, if you are an Adlerian counselor, family is already an important part of the way you work with students. Whereas you might routinely conceptualize your students' behavior as a way to overcome feelings of inferiority and attain superiority and look at such things as birth order and family constellation, what might it add to your work to include, for example, a genogram?

School counselors who may be looking for a model to use with families are encouraged to examine Solution-Focused Brief Family Therapy. The school counselor may not have more than four to six sessions available to work with a family, so this approach is desirable.

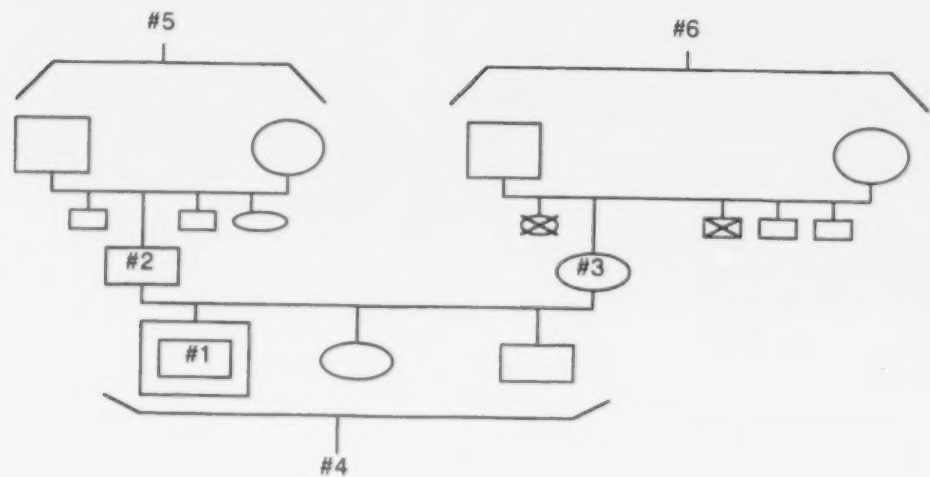


Figure 5.1. A Systemic View of a Student With a Disability

The focus is on competencies and solutions. For example, one family may bring in extended family members to help with a specific problem whereas another family sets aside time to discuss the problematic issues and resolves them in a structured way that involves everyone. Building on "things that work" is important with families. Although time is in short supply for school counselors, there is ample evidence that even short-term work with families has a positive impact.

Another thing school counselors can do is to simply begin to frame issues with children in terms of family problems. This can set the stage for referral to a family counselor, and the school counselor can remain part of the therapeutic system that continues to work with the family as appropriate.

Regardless of your approach to counseling, consider asking a parent to work with you on a genogram (see Figures 5.1 and 5.2). This exercise not only empowers the parent and allows him or her to be the expert, it will also produce very useful information. One parent we know was astonished to discover through this type of effort that most members of her husband's family had significant neurological disorders. It helped her to realize that her odds of having an autistic

<i>Place in Family</i>	<i>Genetic Influence</i>	<i>Family Influence</i>	<i>Cultural Influence</i>
1. Oldest child and son. Recently identified special-needs student (SNS). Frequently reprimanded by parents for poor attitude and work ethic at school.	Inherited genetic predisposition toward verbal and written learning disability.	Moderate paternal pressure to succeed in school due to father's own difficulties. Mother sometimes overprotects from school consequences.	Child is differentiating from his Italian and German farming heritage and is more interested in modern popular culture.
2. Father of SNS. Successful farmer who had difficulty in school and continues to dislike the educational system. Was not identified with a learning disability.	Inherited genetic predisposition toward verbal and written learning disability.	Did not receive much pressure for academic success from parents. Did, however, feel obligated to carry on the family farm and legacy.	Moderate German and farming cultural influence combined with integrated awareness of modern society. High value on work ethic and both physical and mental labor.
3. Mother of SNS. Works as a nurse at local hospital. Academic success came easy for her. Frequently has difficulty balancing professional and spousal identity.	No genetic link to learning disability.	Her siblings' deaths had significant impact. Feels high level of responsibility to maintain family relationships with both her family of origin and creation.	Comes from both Italian and German lineage. Has assimilated to modern culture but maintains some traditional awareness of both lines of heritage.

<i>Place in Family</i>	<i>Genetic Influence</i>	<i>Family Influence</i>	<i>Cultural Influence</i>
4. Siblings of SNS. Younger sister experiences easy academic success. Youngest sibling and brother receives high praise for his "good attitude" in school.	No symptomology of learning disability as of yet.	All three children have close emotional bonds but frequently fight over authority issues (who is in charge) in part due to the oldest's (SNS) insecurity.	Siblings are aware of some cultural heritage but are mostly differentiated and highly identify with "town kids" and popular culture.
5. Family of SNS' father. Close bond between youngest three siblings and parents. Oldest son was alienated from family. Father recently died.	Father and middle sons inherited genetic LD predisposition but none identified.	Agricultural family. Father farmed and mother stayed home. Low value on academics. Little communication about father's death.	Strong German and religious cultural influence. High value on traditional gender roles. Children were discouraged from pursuing education after high school.
6. Family of SNS' mother. Lived in urban area for most of family's life. Father was a factory worker and mother worked as an elementary teacher.	No genetic link to learning disability.	Emotionally close family until death of two children as teenagers in car accident. Parents have since become distant, and youngest son has become an alcoholic.	Italian, Irish, and German lineage; the family is partially assimilated with popular culture and partially tied to Italian traditions.

Figure 5.2. Continued

child (which she had), were greater than for most people. It also helped her understand one reason why her husband's family was very slow to acknowledge or accept her son's disability. (That family was accustomed to unusual behavior and unusual patterns of development in early childhood and did not see either as abnormal.)

Reasons Parents React Differently

Creating effective partnerships with families of children with disabilities requires knowledge of their special issues. Seligman (1979) wrote movingly about the stages of grief that parents of a child who is disabled go through. Often, denial is first, followed by a bargaining stage ("If we can just work really hard with my child, things will get much better"). When full awareness of the situation is established, anger, guilt, and depression may be experienced by parents. Counselors can help with these feelings in several ways, including referring parents to family therapists. Counselors should also remember that these stages of grief can be recycled, or experienced over and over again by parents, as their child develops. New awarenesses of their child's differences can retrigger aspects of the grief process, and we must be sensitive to this pain.

Parents can also feel anger or ambivalence toward their child with a disability. Cycles of optimism and pessimism are not uncommon. Factors such as socioeconomic status, the physical appearance of the child, prior information, religious or spiritual resources, and social support can greatly affect families dealing with a child with a disability.

In looking at patterns among families with children with disabilities, it has been noted in the literature and in the authors' experience that mothers of children with learning disabilities tend to be over-protective, overinvolved, and even enmeshed. Fathers of these children, on the other hand, can be distant, sometimes to the point of disengagement or denial (of the disability or disabling condition). These two reactions reinforce each other, for as fathers establish a distance comfortable to them, mothers feel a need to become even more actively engaged in their child's needs. If both parents are willing to participate in counseling sessions, they might see the

dynamics of the situation more clearly and be able to better support each other and their child.

The depth and range of parents' feelings about children with disabilities are affected by two elements, according to research. The two questions to explore are, "Is the disability acquired or congenital?" and "What is the severity of the disability?" Parents of children with acquired disabilities sometimes show difficulty in adjusting to new situations. This lack of adjustment may be because the family is adapting to the child becoming a person who is now disabled. Parents of children with congenital disabilities, in contrast, often have trouble with achieving emotional distance from their child, due in part to the chronic sorrow of the situation. In either case, the greater the severity of the disability, the more impact there will be on the family.

Reasons for the disability (heredity vs. accident, for example) and how parents found out about it also influence how parents view the child and the situation as a whole. Because of amniocentesis techniques, some families will find out before their child is born that it has a genetically based disability and can prepare in many ways to love and care for that child. Being called by the school and being told in a cold, clinical way that their 6-year-old child has a severe learning disability is another experience entirely. Finding out that a child has a disability almost always precipitates a family crisis. If this information is coming from the school, counselors can be alerted to assist families and to handle communication in the most direct yet gentle manner.

Sometimes it is hard to tell from the outside what level of emotional distance is appropriate between parents and children with disabilities. Because of differences between the child's developmental or emotional level and his or her chronological age, for example, parents may relate to the child in what looks like an odd or out-of-step manner. Counselors are reminded that parents of children with disabilities are used to constant mediation between their children and the world. What might appear to be overinvolvement may really be the best way to help that child cope.

Parenting styles will be different, depending on the needs of the individual child. Parents have usually worked hard to discover what works for their children. On the other hand, some parents can become

discouraged and overwhelmed by their child's needs. School counselors can act as bridges between families and the educational community as well as families and other resources for children with disabling conditions. Counselors are accustomed to referring families to agencies in the community, but must familiarize themselves with organizations such as United Cerebral Palsy, the Autism Society of America, Learning Disabilities Association of America, Children With Attention Deficit Disorders, and the like, when working with students who have disabilities. Most of these groups have local or state chapters that are extremely helpful to parents. Web sites allow parents to network all over the world with people who know a great deal about specific disabilities and treatments as well as school-based interventions (see Resource B for examples).

Counselors can mediate the sometimes volatile feelings that arise in parents raising a child with certain handicaps as well as the strong feelings of teachers who are struggling with classroom management and the needs of groups of children. These mediation skills are invaluable in situations that often pair insecure teachers ("I don't know how to teach your child!") with frustrated parents ("Why do you have that job then?").

These situations, although inherently unfair to all involved, occur frequently in schools. Teachers often resent inclusion, lack training, are afraid of failing, or are apprehensive about how much time and energy the student with disabilities will take away from his or her efforts to work with the rest of the class. Counselors can point out that adversarial relationships among the adults hurt children (as well as being largely unpleasant for the adults), whereas collaborative efforts are more productive for all involved, especially the children.

Individualized Education Program meetings can be ideal opportunities for sharing new information regarding the student and can help change the systems (both school and home) in which the child exists. Decisions based solely on educational information, for any child, without consideration of family circumstances, may in fact be harmful to the student. Within the school, counselors can also point out to teachers the extensive evidence that teaching techniques useful for students in special education are usually effective for all students. In fact, counselors may need to remind themselves that the family

inclusion model, suggested here for working with students with disabilities, is a helpful model for working with all children.

Something else that affects how a family reacts is its stage of family life development. Although there are anticipated stages of family life and development, families with children who have disabilities may not experience all of these stages, or may experience them differently and at atypical times than other families. One major family transition is when children leave home. Most counselors (and parents) will see right away that, for many families with children with disabilities, the children may not leave home "on time," or at all. So, as you examine family systems theory and consider approaches to apply to your own counseling, be sure to be sensitive to ways in which it might need to be adapted for use with families that might not follow the typical pattern or stages.

Remember that these stages are associated with developmental tasks. How the family experiences and negotiates these stages and tasks will affect how they face and get through subsequent stages and tasks. For instance, it is the family's job to successfully socialize young children into the larger community, which includes school. How the family has done this in the past affects how it expects to do this in the future. If a family's first child is a child with a handicap that impairs functioning in school, that experience may color the expectations those parents have when bringing their nondisabled children to school later. Counselors will find it helpful to remember that things of this nature will influence not only families, but how they are viewed by school personnel.

Sexuality

Sexuality is another area in which parents can react differently. The range of values and the somewhat inherent emotionality of this issue are complicated by the effects of disabilities. School counselors can be extremely helpful to parents dealing with the sexual behavior of their child with a disability. They may assist parents in determining what and how to teach the child about sexuality. Counselors can

model dealing with this issue in a straightforward, sensible, sympathetic way.

Although all humans are sexual beings, people with disabilities are viewed as asexual by many. And sometimes those who are seen as sexual are seen as monsters or people who have no self-control. Counselors working in this area may need to use interventions, education, and support with parents.

Puberty is usually a time of great stress for parents of a child with disabilities. This is a time of anxiety for parents of all children, but for parents of children with disabilities it is even more complex. Sexual development can occur as it does typically, which results in one set of challenges; it can also be complicated by certain disabilities. An example is that students identified with an emotional or behavior disorder may express sexuality by exposing themselves in the classroom.

Counselors can provide resources or programs in a variety of areas, such as how to talk with children about sexuality, how to protect children from sexual predators, birth control, homosexuality, masturbation, and how to help children make good decisions. Young people with disabilities need to be able to have healthy self-esteem, good body image, and opportunities to socialize appropriately (Fine, 1991).

Working With the Siblings of Children With Disabilities

Another way to build partnerships with families is to work with the brothers and sisters of children who have disabilities. Siblings of children with disabilities often benefit greatly from attention from the school counselor. This group, even though it is at risk for developing problems, is frequently ignored.

It is well-documented that girls, especially eldest daughters, are affected the most in these families. Girls are often relied on to provide the extra nurturing or to assume other adult responsibilities, making them grow up too fast. On the positive side, the sibling of a child with a handicap can learn empathy and feel needed in the family; on the negative side, the nondisabled child can have unrealistic expecta-

tions put on him or her in order to compensate for the problems of the sibling.

School counselors are well equipped to provide group experiences for children who have brothers or sisters with disabilities. Learning and sharing information about disabilities is a good group activity. Children usually have many unanswered questions about what causes disabilities. They wonder if the disability is contagious ("Will I become deaf, too?"). They wonder if the disability will ever go away ("Will my sister ever be like other kids?"). Discussing feelings and attitudes toward siblings or parents is also helpful. Finding out that their family has common ground with other families that are also unique is comforting to children. Finally, role-playing can help children better understand a parent's role, or even the constraints on the disabled child in the family.

Some siblings of children with disabilities can become advocates for students with disabilities in the school, whereas others have no desire to be singled out in this manner. Obviously, parents and students need to be consulted before pursuing this option.

Slade (1988) points out that school counselors should pay attention to four things in particular when working with the siblings of children with disabilities. These include parental attitude toward the disabled child, the gender and birth order of the nondisabled sibling, the type and severity of the problems affecting the child with disabilities, and the parenting style experienced by the nondisabled sibling. Adjustment problems, academic problems, and behavioral problems can all be exhibited by siblings of children with handicaps, and school counselors should be alert to these concerns.

Family Diversity

School counselors will also notice cultural differences among families. When counselors are White, and families are people of color, incorrect assumptions on both sides will frequently be made. People from some cultures will be extremely reluctant to discuss family issues with an outsider, in this case, the counselor. Excellent resources are available to help counselors learn how to work effectively with

people from varying cultural and ethnic backgrounds (see Suggested Readings).

It is well documented that minority children are overrepresented among special education populations. Some educators believe that children with disabilities constitute a culturally different group simply because of their disabilities. When students with disabilities and their families are also members of a racial or cultural minority group, they may suffer several kinds of oppression. Being informed and aware of these issues can bring counselors from an "I feel sorry for you" place to a more unbiased perspective that acknowledges the complexities faced by these families.

In working with families of various cultures, counselors can relate in ways that allow cultural identity to be a strength (such as using kinship networks) and honoring family values. In any case, matching the best techniques to the child and the unique family situation is vital.

Although many counselors like to think that "all children are children," and this is correct to some extent, there are historical dimensions to working with families of color that cannot be ignored. African American families, for example, report that they often perceive that school personnel make negative assumptions about their families' ability to participate in school-sponsored groups in positive ways. For example, counselors need to ask themselves whether they see parent education as an opportunity for dialogue or a chance to show parents how things are supposed to be done. A "deficit model" that views parent education as addressing weaknesses will not be effective.

Many times counselors are tempted to view nontraditional families as having deficits before really getting to know if that is the case. Some single-parent families, for example, are strong and have a multitude of resources. That stated, however, it is important to watch for financial constraints, emotional overload, and family management issues, especially in families having children with disabilities. With fewer adults to carry responsibility in the family, money and emotional energy can be in short supply. It is important to be aware of these issues when working through the TREAT model.

With all families, and nontraditional families in particular, counselors must be open to very flexible scheduling of appointments and should consider visiting the family home. Even experienced

counselors can mistake difficulty in getting together with lack of parental interest or commitment.

Stepfamilies have distinct issues as well. All stepfamilies have their origins in loss of some type. Disruption of attachment is almost always present. Stepfamilies often begin with unrealistically high expectations. With no shared history of child rearing, a lack of clear roles in the family, and few if any existing patterns or rituals to help them, stepfamilies are challenged in many ways. Counselors can be very helpful in clarifying roles and boundaries. They can also work with children in stepfamilies to encourage the creation of new traditions or rituals that support family stability.

When a stepfamily has a child with disabilities, stresses usually increase. School personnel need to remember that stepparents, for legal reasons, often cannot make emergency medical decisions involving a stepchild. Stepparents may really struggle as they discover what it is like to have daily parental responsibility for a child with a disability.

Adoptive parents have varying concerns, often linked to the age of the child when adopted. The child, if older, may have separation or attachment anxieties or disorders. If there are other children in the family, loyalty conflicts may emerge, especially if the adopted child has disabilities.

Foster parents are often even less empowered. Their interaction with schools usually includes a social worker. Foster parents must have permission from this person for most school-based interventions.

Some parents of students with disabilities have disabilities themselves. These may exacerbate the logistical challenges present with most families, such as transportation and scheduling. This situation requires perhaps the most flexibility on the part of the school counselor, who should work toward joint decision making, even when parents are developmentally disabled.

Nontraditional families are now the majority in our society. Counselors need to remember that insurance issues, confidentiality, legal liability, and family tensions may be very complicated in some families.

We must assume that all of these families want to function successfully as family units and take good care of their children, including those with disabilities. Each family and set of circumstances is

unique, however, and counselors will be required to show sensitivity, respect, and professionalism in all cases. This is especially challenging when parents and counselors have different values (e.g., cohabiting parents, drug-using parents, homosexual parenting partners). If counselors can consistently present themselves as a positive resource to families and remain optimistic about most people deeply wanting to be good parents, much can be accomplished.

Concluding Comments

It is important for counselors to help others remember to not focus on the "problems" of the individual child, but to see the larger context, including family dynamics, school situation, and even community. The systems perspective, with which most counselors are familiar, lends a more universal view.

Family systems counseling is emerging as the treatment of choice for many problems. In the school setting, the child is usually seen as the identified "person with a problem." This is particularly true in the case of a child who has a disability; the child is seen as the one who is involved with counseling. A systems approach may startle family members at first, who may prefer to think of that child as the one with the problem. When families can come to understand the systemic nature of many issues for children, they may be eager to join in family therapy.

Even in cases where the child is the one with an identified problem, as is most common to situations initiated by schools, it is helpful and often hope-instilling for family members to participate in counseling. For example, families with a child who has Fragile X syndrome may be astonished at how valuable it is to experience the support of good counseling. A systems approach can help the family look at how living with a child who has a significantly challenging disability affects marital and sibling relationships, and adds stress to many aspects of family life. In addition to the hard work of "regular" parenting, the parents and family members of this child must come up with almost superhuman amounts of patience, creativity, and resourcefulness.

What else can school counselors do to work better with the families of children with disabilities? We all know at some cognitive level that the children we see in our schools are parts of systems that change whenever one part (person) alone is changed or treated, but we seem to forget it in important ways and times. We also know that, with families, the whole is greater than the sum of its parts, but often we still focus on just that "part"—or child—before us. Although many of us may not have the time or expertise to do family therapy, we can and must make the time and familiarize ourselves with the resources available for good referrals. And counselors can certainly be the available and honest communication link between school personnel and families, all of whom care about the success of children.

A final word on ways counselors can help students with disabilities and their families: advocacy. Being an advocate can mean sponsoring creative programs, such as the "circle of friends" networks or friendship groups for students with or without disabilities. Other "buddy" programs assign a student without disabilities to assist a student with disabilities in a certain task or activity, such as hanging out at recess or tutoring in math.

Students with disabilities are often totally excluded from extracurricular activities other than those designed for them, such as the Special Olympics. Parents report that they must be assertive in getting permission for their children to participate in extracurricular activities. They also are required to bend their schedules in ways other parents do not in order to accommodate scheduling and transportation needs. In fact, many parents of children with disabilities must become the coach or activity leader if they want their child to be included. Counselors can advocate for these students and parents within the school setting and commit the school to increasing access to activities for all students. If counselors are willing to serve as the catalysts for these kinds of changes, it is an immense help to families.

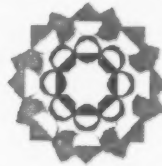
Counselors can also provide expertise with regard to laws affecting students with disabilities. This knowledge, shared with both school personnel and parents, can protect all parties. More than half of the families of children with disabilities interviewed for a recent study had initiated either due process hearings or court proceedings against the schools to obtain services needed for their children with

disabilities. (Family members have the right to request a due process hearing if they think that any of their children's rights have been violated by the school.) Elucidating the situation before it becomes adversarial, particularly in the legal sense, can be a key counselor role.

Finally, counselors realize that the need for advocacy for students with disabilities does not end when the student graduates. Teaching families and students with disabilities to become effective advocates for themselves is essential.

6

Making a Difference in the Wider Circle of Caring



In large group guidance, school counselors handle a wide range of subjects. All students have normal developmental issues that lend themselves well to this format. Group guidance also allows counselors to work with many students at once, which is simply a necessity, given limited resources.

Students with disabilities should not be excluded from these activities, either overtly or covertly. Classroom guidance seems to be the time when students with disabilities are pulled out for other services (e.g., speech and language, occupational therapy, physical therapy, academic remediation). Counselors must advocate for keeping all students in the classroom for these activities.

Most school administrators have come to realize the positive differences comprehensive developmental guidance programs can

achieve with students. Muro and Kottman (1995) state that the best guidance programs are built on twelve basic principles. We, too, believe that high quality guidance programs are built on these principles. Our goal in this chapter is to make explicit the implicit benefits of this framework for students with disabilities. These principles are included in the following paragraphs, along with comments regarding their application or extension to all students, especially those with disabilities. (The following italicized statements are borrowed from Muro and Kottman [1995].)

The first principle is that guidance and counseling are needed by all children. This principle suggests that, yes, students with disabilities can and will benefit from classroom guidance. You may have to protect students on IEPs from being pulled out of the classroom during guidance activities or small group work. You will need to remind classroom teachers, resource room teachers, or even the multidisciplinary team members that students with disabilities have a legal right to the benefits of the developmental guidance program in your school.

Developmental guidance and counseling has a focus on children's learning. This principle is of special importance when it comes to children with unique learning needs. An integral part of a counseling program is to enhance student learning, or "help learners learn." In some cases this will require more intervention than in others. Although classroom guidance activities will support this process, some students may need to have small group assistance, too. Psychoeducational groups and classroom guidance activities that focus on such skills as studying, organizing, and test-taking are particularly needed by students who are disabled.

Counselors and teachers are cofunctionaries in developmental guidance programs. For the most part, in elementary schools (in contrast to most middle and high schools), the students are in self-contained classrooms. Teachers in this setting are more concerned with the whole child, rather than specific subject matter. Because of this, most elementary teachers will want to work collaboratively with school

counselors. Teachers in middle and high school settings also care a great deal about their students, but it is harder for them to pinpoint social or behavior problems because they typically have students only 1 hour each day. Counselors in either setting may be asked to come up with suggestions, such as active learning techniques or cooperative learning groups, in order to help students succeed. Counselors may also be asked to create behavioral management plans for students who need help in eliminating problematic conduct.

An organized and planned curriculum is a vital part of developmental guidance. Just as in any curricular area, guidance should be organized around specific topics. These topics usually include career development, self-management, motivation, self-esteem, and other social-emotional and life skills areas. The school counselor needs to have curriculum units that address these areas, and these units should include appropriate modifications to make the material accessible to all students in the classroom. Appropriate modification might mean that a lesson on helping children cope with fears that includes a story being read aloud would have an interpreter for the hearing impaired student in the class. Guidance activities often include discussion. If there is a student who is mute or has expressive language disorder, an option is to have laminated words and letters the child can select and share in order to participate. You may find that these alternatives help not only the students with disabilities, but also other students in the group.

Developmental guidance is concerned with self-acceptance, self-understanding, and self-enhancement. It is critical that counselors promote these traits when working with students with disabilities. These traits may best be promoted in small groups of children with similar disabilities and/or individual counseling.

For example, students with specific learning disabilities comprise the largest subset of children with disabilities. Grouping together four to six of these students weekly for 6 weeks would give them a chance to see what makes them unique as learners as well as what they have in common. In a small group, students may share coping techniques and other resources. They may also come to recognize the

special contributions they can make to their school. (The appendix provides a complete group unit for students with learning disabilities.) As you know, group work lends universality to participants; in this case, students with learning disabilities discover that they are not alone in their struggles. Students can also practice new skills in a safe environment. Groups give a sense of belonging and acceptance and allow members to improve their social skills in a smaller model of the classroom.

Developmental guidance and counseling focus on the encouragement process. Counselors need to be in the business of instilling hope, especially with children. Some students with disabilities carry a great sense of discouragement every day. They are aware of their differences. Students who use wheelchairs know they will never jump like Michael Jordan. Those with reading disabilities often believe that they are not smart. The counselor's job is to support all students in discovering the areas in which they can excel and appreciate the abilities they have. So, although the student using a wheelchair may not be able to jump, he or she could actively participate in wheelchair basketball.

Developmental guidance acknowledges directional development rather than definitive ends. After reading this book, you may notice that this statement is in great contrast to the philosophy reflected by IEP's. Such philosophical disagreement can be frustrating for counselors, who know that counseling is a process, not an event. Although you will be expected to be able to write measurable goals and objectives, remember that you are working with young people who are not finished products. They will continue to learn and grow and experience difficulties and successes along the way. You may enter and reenter their lives through both the special education and regular education processes, dealing with different issues at different developmental stages.

Developmental guidance, although team-oriented, requires the services of a trained professional counselor. Although all school personnel are involved in the overall education of students, counselors bring specialized skills in behavior management, child development, individual

and group counseling, school-to-work transitions, and more. Counselors and guidance programs optimize and promote the mission of the school and the work of other professionals within it.

Developmental guidance is concerned with early identification of special needs. Increasingly, school counselors are called on to assess young children with developmental delays. Many schools invite counselors to participate in "kindergarten round-up" and to assess specific areas by asking key questions, such as "How well does Matthew play with other children?" "Does Callie share her toys?" "What does Bobby do when he is told no?"

Developmental guidance is concerned with the psychology of use. Counselors are as concerned with helping students maximize their potential as they are with a diagnosis or results of an assessment. Even though Jerome is sight impaired, he reads very well in Braille and has superb musical talent. It is important to focus on the student's abilities, not his or her disabilities. Counselors can link student interests to opportunities within and outside school to develop interests and aptitudes.

Developmental guidance has foundations in child psychology, child development, and learning theory. A guidance program needs to "fit" all students, even (or especially) those with disabilities. As mentioned earlier, modifications based on specific disabilities have to be integrated with the overall developmental guidance program.

Developmental guidance is both sequential and flexible. Flexibility is essential in school guidance programs. Capturing the range of developmental differences, typical or atypical, in any classroom, requires the ability to be responsive. Within this necessary range of adaptability, however, school counselors should have a plan that is clearly defined. These two qualities allow for optimum program effectiveness.

Concluding Comments

This book challenges counselors to make a difference in the lives of students with disabilities and their families. Counselors will be

increasingly engaged in special education work, whether or not they choose to embrace it. The time has passed when counselors can be passive participants in the education process of students with disabilities. Approaching these tasks in an informed and competent manner will allow counselors to demonstrate yet another facet of professional leadership in their schools.

In order for school counselors to be effective members of the multidisciplinary team, there is information and knowledge they must gather. At a minimum, school counselors need to become familiar with the laws of IDEA and Section 504. You need to have a basic understanding of the most commonly occurring disabling conditions (learning disabilities, developmental delays, ADHD, and the continuum of emotional/behavioral disorders), their causes, symptoms, and treatments. Look at a final example. Do you feel better prepared to provide the right counseling interventions for this student?

Donny is a student in Mrs. Jones's second grade classroom. Mrs. Jones says Donny just cannot attend to anything that is going on in her classroom. Donny is constantly looking around, and is in and out of his desk a dozen times before morning recess. Instead of raising his hand, Donny will blurt out what he hopes to be the answer, but generally his remark has something to do with his animals at home. Donny loves his pets, and is very good to them.

With other kids, Donny seems to have a habit of acting first and thinking later. For example, during lunch yesterday, while he waited to empty his tray, he purposely upset the tray of the boy standing in front of him and seemed very confused when he was confronted about his behavior by the lunchroom supervisor. Donny's mother thinks that he is just a little "hyper" and gets overexcited at times.

Does Donny have a disability? What are Donny's special needs? What, if any, is your responsibility for addressing those needs? Because you have read this book, you know that you will keep track of your personal observations of Donny as well as get impressions from parents and teachers, both formal and informal. You will note whether his behavior is significantly different from that of other 7-year-old boys. You will review his school records. You will talk with

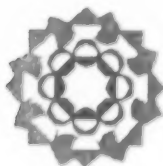
Donny himself about what he thinks is going on with his behavior in school.

Maybe Donny would best be helped by being in a small group of boys his age who need help with social and attending skills. Or maybe his behavior is evidence of something more serious, such as ADHD. Your work as the school counselor will be key in determining an accurate assessment and possible interventions with this child. How this situation is handled may make the difference between Donny's success or failure in school.

Now let's go back to the scene that opens this book: You come into the office at the end of a productive day. You have done classroom guidance with the aid of an interpreter. In one of your friendship groups, you used a variety of experiential materials to accommodate students with learning disabilities. You set up parent education groups, including one for parents of students with disabilities. That is when you see it: the IEP notice. How do you react? Well, you may still be exasperated at the thought of more work. You might still be frustrated because you do not feel you have expertise in special education. But you may, as you look over the notice, begin to have positive thoughts about what you bring to the IEP setting. You may even start mentally formulating goals and objectives for the student in areas such as social development and career guidance, in which you feel especially competent. And on a good day, you might even smile and think, "I'm ready!"

Resource A

Understanding and Coping With Learning Disabilities: A Support Group for Middle Schoolers With Specific Learning Disabilities



Group description: The "Understanding and Coping With Learning Disabilities" group is designed for male fifth and sixth graders who have been identified as having a specific learning disability. Plan to include four to six students. The group needs to be large enough to encourage group interaction and yet small enough to allow each of the boys a chance to participate. The group will meet for eight sessions. Each session will be 45 minutes long. Sessions will include a warm-up activity, a central activity, and a closing activity that at times will include homework. Membership within the group should be voluntary.

Group goals: One of the many benefits of group counseling is that students realize the commonality of their problems. Students with disabilities may gain significant personal and academic confidence through a supportive and understanding environment, opportunities to create new friendships, and gaining greater self-awareness of their own unique learning styles. The main goals or outcomes of this group are the following:

- Increase students' understanding and valuing of their unique learning styles
- Help students gain a realistic picture of their disabilities and how they might compensate for varying learning problems
- Assist students in learning new ways of coping and gaining feelings of worthiness
- Help students understand that other students also have learning disabilities and experience similar problems and feelings

Contact parents or guardians by letter to explain the nature and goals of the group. Parents should be required to send a signed permission slip back to the school before their child can participate. You will want to keep this as a part of your personal records.

Prescreening and orientation: After recruiting potential members, meet with students individually to help determine if they are ready for a group counseling experience. Potential members should be encouraged and given the opportunity to ask questions and to decide if they are interested in joining the group. After individual initial screening and acceptance, have each member complete the Roles Questionnaire and Skills for Study Success Checklist. These will serve as a pre- and posttest measure. Finally, ask members to bring an unmarked bag from home containing six items that describe something about who they are. You should have a bag of your own items ready to demonstrate the activity to each student during the first counseling session. After students agree to participate and return their permission slips, ask students to bring their bags of belongings to the first group session.

Session One: Who Am I?

Goal: To increase group members' understanding and appreciation of individual uniqueness.

Objectives: Group members will be able to:

- Select items that represent aspects of their personality
- Discuss the meaning of items they brought to the group
- Recognize similarities and differences between group members

Materials: Brown grocery bag, six personal items from home that represent various aspects of the group members' personalities, likes, and dislikes.

Procedures:

1. Introduce yourself to the group members. Have students introduce themselves. Reexplain the purpose of the group. For example, "We are meeting as a group to talk and learn about something that each of you has in common. Each of you has a unique and special way that you learn best. My job is to help you explore more about how you learn best and be able to explain that to others, most important, your teachers."
2. Ask group members to suggest rules for the group so that the group will work together well. Get agreement on any rules that are adopted. Write the rules down so that they can be referred to when necessary.
3. After the group members have introduced themselves and agreed on group rules, have students empty their bags before the other group members. Gently mix together the items and have students write down on a piece of paper who he or she believes each item belongs to. Go through all items and have the owners identify themselves and explain why they included each item.
4. Facilitate a discussion about what members were saying about themselves by the items they chose to bring and share with the group.

5. As a final step, ask group members to summarize the purpose of the group, the group rules, and something new that they learned about themselves or another group member during the initial group session.

Adapted from Canfield, J., & Wells, H. C. (1976). *100 ways to enhance self-concept in the classroom*. Englewood Cliffs, NJ: Prentice Hall.

Session Two: Getting to Know You

Goal: To help students work together as a team to solve problems.

Objectives: Group members will be able to:

- Cooperate with one another to assess and complete a task
- Generate possible solutions and make a decision as a group
- Offer encouragement to one another to complete a specific task

Materials: Rubber kick ball, small sturdy table, and large open space (school gym or playground).

Procedures:

1. Review last week's activities, group rules, and have members share how things are going.
2. The following activities will need to be introduced by demonstration. As the group leader, you should participate in each activity except for "All Aboard." You will need to be the official time keeper and safety person for that particular activity.
 - Lap Ball: All members sit in a very close circle, shoulder to shoulder, legs stretched straight out in front. The object of the game is to pass the ball from lap to lap around the circle three times without using hands.
 - All Aboard: This activity will require a small table not quite big enough to allow all group members to sit on it. Ask students to get on and stay on the table for 10 seconds. If no table is available, tumbling mats will work well, too.

- **Stand Up:** With a partner, group members sit back to back, arms interlocked at the elbow with knees bent. The object of this activity is to stand up. If you have uneven numbers in your group, or very agile students, three or four and even five students can try to complete this activity.

Process how members feel about each of the activities in Procedure 2 and how well they believe they worked together to solve a common problem.

Adapted from Duncan, Beck, & Granum (1988). Project explore: An activity-based counseling group. *The School Counselor*, 35(3), 215-219.

Session Three: Learning Styles and Preference Inventories

Goal: To help students develop a better understanding of themselves as unique and capable learners.

Objectives: Group members will be able to:

- Assess their preferred modes of learning
- Discriminate between likes and dislikes in terms of learning information
- Reflect on unique learning styles

Materials: Learning Styles Inventory (LSI), video explaining learning disabilities for student viewers.

Procedure:

1. Explain the purpose of the inventory and administer the learning styles instrument; collect and score completed instruments after group session.
2. View video.
3. Process the video.

Closure: "Today I learned something new; it was ____."

Session Four: How I Learn Best

Goal: To help group members understand their own learning patterns.

Objectives: Group members will be able to:

- Identify environmental learning preferences
- Identify their preferred mode of learning

Materials: Results from the Learning Styles Inventory (LSI) and Personal Preferences Of . . . and a list of each student's disability type.

Procedures:

1. Hand out maximizer and LSI results; give each student time to read results and assist if necessary.
2. On flip chart or blackboard, list specific elements (temperature, responsibilities, etc.) of the inventories. Have students report their scores one by one as you record their percentiles on a continuum line or some other device that allows group members to see differences.
3. Process the following types of questions:
Who in our group enjoys learning in the morning/night?
Who in our group prefers a cooler/warmer environment?
Who in our group prefers to work in groups/alone?

Closure: "One thing I learned today was ____."

Session Five: Learning Life Line

Goal: To assist group members in identify significant events, achievements, and successes unique to them.

Objectives: Group members will be able to:

- Show through symbols significant learning events unique to them

- Share with group members some personal learning success or achievement

Materials: Large sheets or rolls of white paper (freezer wrap works well), lots of different types of magazines that depict children learning to do things, colored markers, crayons, paints, magazines, and scissors.

Procedure:

1. Have students think back to special events in their lives when they learned to do something new (e.g., riding a bike, jumping rope, throwing a ball, putting a worm on a hook, flying a kite, singing a song, making a bed, adding or subtracting).
2. Have each group member then draw or cut out pictures that represent those successful learning experiences and have them create a "Learning Life Line."

Session Six: My Special Talents and Abilities

Goal: To help students recognize and verbalize their talents and abilities.

Objectives: Group members will be able to:

- Identify their unique talents and abilities
- Recognize that individuals differ in talents and abilities

Materials: A copy of "My Talents and Abilities," (attached), pens and pencils, unique learner folder.

Procedures:

1. After check-in, write the words academic, athletic, artistic, and musical on the chalkboard or flip chart. Explain to the group members that these are categories in which students have different abilities and talent. Provide some examples of indi-

viduals who seem to excel in each area and individuals who do not perform well in a particular area. For example, how well do you believe Michael Jordan can sing? How well do you think Albert Einstein could play soccer? How well can Tiger Woods paint?

2. Next, ask group members to brainstorm activities that fall within each category. Write them on the board as members call them out. For example: Academic: honor roll, gets all A's and B's; Athletic: good basketball player, gets good grades in P.E.; Artistic: draws people and animals well, good grades in art; Musical: plays in the band, takes piano lessons, sings well, gets good grades in music.
3. Pass out "My Talents and Abilities" and have students write down as many talents or abilities they believe they have and have them place a mark in the box that they think each talent or ability falls within.
4. Ask group members to share the category or categories in which they found most of their strengths. Ask group members which activities they have not explored, but are interested in or might succeed in if they tried it.
5. If there is time, the counselor may want to make a group chart to demonstrate group strengths.

Closure: Ask group members what new information they have about themselves and other group members. What conclusions might they draw based on the new information they have gathered? Have group members add their "Personal Talents and Abilities" sheet to their "Unique Learner" folders.

My Personal Talents and Abilities

Name _____

Athletic:

Academic:

Musical:

Artistic:

Drama:

Session Seven: Marketing Ourselves

Goal: To help students recognize and verbalize their special talents and abilities.

Objectives: Group members will be able to:

- Create advertisements about themselves
- "Sell" themselves and their abilities

Materials: Paper, pencils, tape recorder, colored markers, paper pictures of themselves, etc.

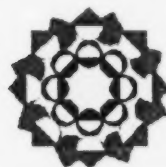
Procedure:

1. After check-in, have members break into groups of two and review their "Unique Learners" folder. Have students evaluate the uniqueness of each individual, taking into consideration strengths, talents, abilities, personal preferences, etc.
2. Have members create radio ads and/or newspaper ads selling their unique learning styles.
3. Conclude the session by having each member present his or her ad to the group.

Closure: Have group members process how it feels to learn differently than other members in the group and students in the school.

Resource B

Organizations



American School Counselor Association (ASCA)

1-800-306-4722

<http://www.schoolcounselor.org>

Autism Society of America (ASA)

7910 Woodmont Avenue, Suite 650

Bethesda, MD 20814

http://www.autism_society.org

Attention Deficit Disorders Association (A.D.D.A.)

8091 South Ireland Way

Aurora, CO 80016

(800) 487-2282

<http://www.add.org>

Attention Deficit Disorders Association of Parents
and Professionals

Together (ADDAPPT)

P.O. Box 293

Oak Forest, IL 60452

Publishes *ADDaptibility Newsletter*

Children and Adults With Attention Deficit Disorders
(C.H.A.D.D.)

499 NW 70th Ave. #109

Plantation, FL 33317

(305) 587-3700

<http://www.chadd.org>

Council for Exceptional Children (CEC)

1920 Association Drive

Reston, VA 22091

FAX (703) 264-9494

(703) 620-3660 / (703) 264-9462

<http://www.cec.sped.org>

Learning Disabilities Association of America (LDAA)

4156 Library Road

Pittsburgh, PA 15234

(412) 341-1515

<http://www.ldanatl.org>

National Center for Learning Disabilities (NCLD)

381 Park Ave. S., Suite 1420

New York, NY 10016

FAX (212) 545-9665

(212) 545-7510

<http://www.nclld.org>

National Mental Health Association (NMHA)

1021 Prince Street

Alexandria, VA 22314-2971

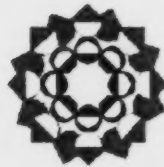
FAX (703) 684-5968

(703) 684-7722

(800) 969-6642

<http://www.nmha.org>

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Suggested Readings

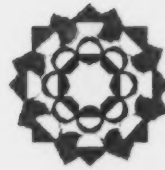
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